

Arizona

UNIFORM APPLICATION FY 2006

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 08/26/2004 - Expires 08/31/2007

(generated on 1-11-2006 11.19.58 AM)

Center for Substance Abuse Treatment
Division of State and Community Assistance

Introduction:

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane. Rockville. MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0080.

Form 1

State: Arizona

DUNS Number: 804 745 420

**Uniform Application for FY 2006 Substance Abuse
Prevention and Treatment Block Grant**

I. STATE AGENCY TO BE THE GRANTEE FOR THE BLOCK GRANT

Agency Name: Arizona Department of Health Services

Organizational Unit: Division of Behavioral Health Services

Mailing Address: 150 North 18th Avenue, Ste.220

City: Phoenix

Zip: 85007

II. CONTACT PERSON FOR THE GRANTEE FOR THE BLOCK GRANT

Name: Susan Gerard, Director

Agency Name: Arizona Department of Health Services

Mailing Address: 150 North 18th Avenue

City: Phoenix

Zip Code: 85007

Telephone: (602) 542-1025

FAX: (602) 542-1062

III. STATE EXPENDITURE PERIOD

From: 7/1/2003

To: 6/30/2004

IV. DATE SUBMITTED

Date: 9/23/2005

☒ Original

☐ Revision

V. CONTACT PERSON RESPONSIBLE FOR APPLICATION SUBMISSION

Name: Christina Dye

Telephone: (602) 364-4652

E-MAIL: DYEC@azdhs.gov

FAX: (602) 364-4763

UNIFORM APPLICATION FOR FY 2006 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT Funding Agreements/Certifications as Required by the Public Health Service (PHS) Act	
<p><i>The PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.</i></p> <p>We will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.</p>	
I.	Formula Grants to States, Section 1921
Grant funds will be expended “only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities” as authorized.	
II.	Certain Allocations, Section 1922
<ul style="list-style-type: none"> • Allocations Regarding Primary Prevention Programs, Section 1922(a) • Allocations Regarding Women, Section 1922(b) 	
III.	Intravenous Drug Abuse, Section 1923
<ul style="list-style-type: none"> • Capacity of Treatment Programs, Section 1923(a) • Outreach Regarding Intravenous Substance Abuse, Section 1923(b) 	
IV.	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924
Group Homes for Recovering Substance Abusers, Section 1925 Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.	
The State “has established, and is providing for the ongoing operation of a revolving fund” in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.	
VI.	State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926:
<ul style="list-style-type: none"> • The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1). • The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1). • The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2). 	
VII.	Treatment Services for Pregnant Women, Section 1927
The State “...will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant.”	
VIII.	Additional Agreements, Section 1928
<ul style="list-style-type: none"> • Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a) • Continuing Education, Section 1928(b) • Coordination of Various Activities and Services, Section 1928(c) • Waiver of Requirement, Section 1928(d) 	

IX.	Submission to Secretary of Statewide Assessment of Needs, Section 1929
X.	Maintenance of Effort Regarding State Expenditures, Section 1930
	With respect to the principal agency of a State, the State “will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.”
XI.	Restrictions on Expenditure of Grant, Section 1931
XII.	Application for Grant; Approval of State Plan, Section 1932
XIII.	Opportunity for Public Comment on State Plans, Section 1941
	The plan required under Section 1932 will be made “public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.
XIV.	Requirement of Reports and Audits by States, Section 1942
XV.	Additional Requirements, Section 1943
XVI.	Prohibitions Regarding Receipt of Funds, Section 1946
XVII.	Nondiscrimination, Section 1947
XVIII.	Services Provided By Nongovernmental Organizations, Section 1955
	I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.
	State: Arizona
	Name of Chief Executive Officer or Designee: Susan Gerard
	Signature of CEO or Designee:
	Title: Director Date Signed:
	If signed by a designee, a copy of the designation must be attached

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about –
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

- (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
- (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any

person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

<p>5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE</p> <p>Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.</p> <p>Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.</p>	<p>By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.</p> <p>The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.</p> <p>The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.</p>	
SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director	
APPLICANT ORGANIZATION Arizona Department of Health Services		DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance		2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award		3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____	
4. Name and Address of Reporting Entity: <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known: _____ Congressional District, if known: _____			5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known: _____		
6. Federal Department/Agency: 			7. Federal Program Name/Description: CFDA Number, if applicable: _____		
8. Federal Action Number, if known: 			9. Award Amount, if known: \$ _____		
10.a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i> 			b. Individuals Performing Services <i>(including address if different from No. 10a.) (last name, first name, MI):</i> 		
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.			Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____		
Federal Use Only:					Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

Authorized for Local Reproduction
Standard Form – LLL (Rev. 7-97)

**DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET**

Reporting Entity:

Page

of

Authorized for Local Reproduction
Standard Form – LLL -A

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

Approval Expires: 08/31/2007

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director	
APPLICANT ORGANIZATION Arizona Department of Health Services		DATE SUBMITTED

State:
Arizona

FY 2003 SAPT BLOCK GRANT

Your annual SAPT Block Grant Award for FY 2003 is reflected on Line 8 of the Notice of Block Grant Award

\$30,548,743

Attachment A

State:
Arizona

Attachment A: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

☒ Yes ☐ No ☐ Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

☒ Yes ☐ No ☐ Unknown

3. Does your State alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT BLOCK GRANT

☐ Yes
☒ No
☐ Unknown

OTHER STATE FUNDS

☐ Yes
☒ No
☐ Unknown

DRUG FREE SCHOOLS

☐ Yes
☒ No
☐ Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

☒ Yes ☐ No ☐ Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau? ☐ Yes ☐ No ☒ Unknown

Dissemination of materials? ☒ Yes ☐ No ☐ Unknown

Media campaigns? ☐ Yes ☐ No ☒ Unknown

Product pricing strategies? ☐ Yes ☒ No ☐ Unknown

Policy to limit access? ☒ Yes ☐ No ☐ Unknown

6. Does your State now have laws that suspend or revoke administrative drivers' licenses for those determined to have been driving under the influence of intoxicants? (HP 26-24)

☒ Yes ☐ No ☐ Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers,

☐ Yes ☒ No ☐ Unknown

New product pricing,

☐ Yes ☒ No ☐ Unknown

New taxes on alcoholic beverages,

☐ Yes ☒ No ☐ Unknown

New Laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors,

☒ Yes ☐ No ☐ Unknown

Parental responsibility laws for a child's possession and use of alcoholic beverages.

☐ Yes ☒ No ☐ Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

☒ Yes ☐ No ☐ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older? .08

Motor vehicle drivers under age 21? .08

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other drug abuse prevention (HP 26-3)?

15

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences (HP 26-11 and 26-16)?

☐ Yes ☒ No ☐ Unknown

Attachment I

State:
Arizona

Attachment I

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

Attachment I - Charitable Choice

For the fiscal year prior (FY 2005) to the fiscal year for which the State is applying for funds provide a description of the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries - Check all that apply:

- ☒ Use model notice provided in final regulations.
- ☐ Use notice developed by State (attached copy).
- ☒ State has disseminated notice to religious organizations that are providers.
- ☒ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- ☐ State has developed specific referral system for this requirement.
- ☒ State has incorporated this requirement into existing referral system(s).
- ☐ SAMHSA's Treatment Facility Locator is used to help identify providers.
- ☐ Other networks and information systems are used to help identify providers.
- ☐ State maintains record of referrals made by religious organizations that are providers.
- ☐ 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ('alternative providers'), as define above, made in previous fiscal year. Provide total ONLY; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

The Arizona Department of Health Services is the Single State Authority for the SAPT Block Grant. The ADHS/Division of Behavioral Health contracts for a regionalized system of substance abuse treatment and prevention services through five Regional Behavioral Health Authorities. The RBHAs receive the majority of SAPT Block Grant funds for treatment services and are accountable for compliance requirements of the Grant. During FY 2004, the ADHS/DBHS developed and implemented a notice and referral process consistent with the Charitable Choice regulations for community providers, including religious and faith-based organizations, that subcontract with the RBHAs for delivery of SAPT Grant funded treatment services. The implementation process included provision of technical assistance to the RBHA Substance Abuse Coordinators at three quarterly meetings and publication of the notice and referral requirements in the ADHS/DBHS Provider Manual effective July 2004.

State:
Arizona

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- ☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d))
- ☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))
- ☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))
- ☐ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))
- ☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as Attachment J to the application. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively.

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

State:
Arizona

Dates of State Expenditure Period:
From 7/1/2003 to 6/30/2004

Activity	A. SAPT Block Grant FY 2003 Award (Spent)	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance abuse treatment and rehabilitation	\$22,343,290	\$28,092,326	\$	\$14,604,477	\$5,056,209	\$
2. Primary Prevention	\$6,115,130		\$	\$146,401	\$	\$
3. Tuberculosis Services	\$	\$	\$	\$	\$	\$
4. HIV Early Intervention Services	\$1,527,437	\$	\$	\$	\$	\$
5. Administration (excluding program/provider level)	\$562,886		\$337,165	\$	\$80,000	\$
6. Column Total	\$30,548,743	\$28,092,326	\$337,165	\$14,750,878	\$5,136,209	\$

Primary Prevention Expenditures Checklist

State:
Arizona

	Block Grant FY 2003	Other Federal	State	Local	Other
Information Dissemination	\$700,000	\$21,112	\$3,001	\$	\$
Education	\$3,140,000	\$241,428	\$85,000	\$	\$
Alternatives	\$2,140,000	\$129,355	\$58,000	\$	\$
Problem Identification & Referral	\$25,130	\$	\$50	\$	\$
Community-Based Process	\$55,000	\$443	\$175	\$	\$
Environmental	\$55,000	\$443	\$175	\$	\$
Other	\$	\$	\$	\$	\$
Section 1926 - Tobacco	\$	\$	\$	\$	\$
TOTAL	\$6,115,130	\$392,781	\$146,401	\$	\$

Resource Development Expenditure Checklist

State:
Arizona

Did your State fund resource development activities from the FY 2003 block grant?

☐ Yes ☒ No

	Treatment	Prevention	Total
Planning, Coordination and Needs Assessment	\$	\$	\$
Quality Assurance	\$	\$	\$
Training (post-employment)	\$	\$	\$
Education (pre-employment)	\$	\$	\$
Program Development	\$	\$	\$
Research and Evaluation	\$	\$	\$
Information Systems	\$	\$	\$
TOTAL	\$	\$	\$

Expenditures on Resource Development Activities are:

☒ **Actual** ☐ **Estimated**

SUBSTANCE ABUSE ENTITY INVENTORY

State:

Arizona

				FISCAL YEAR 2003			
1. Entity Number	2. National Register (I-SATS) ID	3. Area Served	4. State Funds	5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
03	AZ100954	Yuma and La Paz Counties	\$384,435	\$986,943	\$40,684	\$179,669	\$38,838
15	AZ100442	Northern Arizona 5 Counties	\$1,777,951	\$2,375,878	\$113,566	\$330,920	\$68,047
23	AZ102232	Pinal and Gila Counties	\$753,768	\$808,978	\$54,087	\$237,591	\$43,357
24	X	Pima and Southeastern AZ 5 Cos	\$3,867,297	\$5,186,666	\$731,952	\$1,640,508	\$383,318
55	X	Maricopa County	\$7,538,374	\$12,845,576	\$1,980,811	\$3,706,242	\$956,327
60	X	Statewide (optional)	\$	\$	\$	\$	\$15,026
70	X	Statewide (optional)	\$	\$	\$	\$	\$19,974
80	X	Gila River Indian Community	\$45,800	\$139,250	\$4,677	\$10,200	\$2,550
81	X	Statewide (optional)	\$	\$	\$	\$5,000	\$
82	X	Statewide (optional)	\$	\$	\$	\$5,000	\$
TOTAL	TOTAL	TOTAL	\$14,367,625	\$22,343,291	\$2,925,777	\$6,115,130	\$1,527,437

PROVIDER ADDRESS TABLE

State:

Arizona

Provider ID	Description	Provider Address
24	CPSA	4575 East Broadway, Tucson, , 85711, 520-325-4268,
55	VALUEOPTIONS	Four Gateway Plaza, 444 N. 44th Street, Suite 400, Phoenix, , 85008, 602-914-5800,
60	Arizona State Laboratory	250 N. 17th Avenue, Phoenix, , 85007, 602-542-0356,
70	Office of HIV STD Services	Az Dept of Hlth Svces, 150 N. 18th Ave., 1st floor, Phoenix, AZ, 85007, 602-364-3610,
80	Gila River Indian Community	P.O. Box 97, Sacaton, AZ, 85247, 602-528-1343,
81	EMPACT Suicide Prevention Center	1232 E. Broadway Rd., Suite 120, Tempe, AZ, 85282, 480-784-1514,
82	Information & Referral Service-Tucson	3130 N. Dodge Blvd., Tucson, AZ, 85716, 520-323-1303,

Prevention Strategy Report

State:

Arizona

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Brochures [4]	1
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	1
	Parenting and family management [11]	1
	Ongoing classroom and/or small group sessions [12]	1
	Preschool ATOD prevention programs [16]	1
	Recreation activities [26]	1
	Multi-agency coordination and collaboration/coalition [43]	1
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	1
	Brochures [4]	3
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	3
	Parenting and family management [11]	3
	Mentors [15]	1
	Recreation activities [26]	1
	Multi-agency coordination and collaboration/coalition [43]	1
Violent and Delinquent Behavior [4]	Brochures [4]	2
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	2
	Ongoing classroom and/or small group sessions [12]	2
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	2
	Mentors [15]	1
	Multi-agency coordination and collaboration/coalition [43]	1
Economically Disadvantaged [6]	Clearinghouse/information resources centers [1]	5

Form 6a: Risk - Strategies (...continued)

State:

Arizona

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Economically Disadvantaged [6]	Resources directories [2]	1
	Media campaigns [3]	2
	Brochures [4]	38
	Radio and TV public service announcements [5]	2
	Speaking engagements [6]	34
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	38
	Information lines/Hot lines [8]	2
	Parenting and family management [11]	29
	Ongoing classroom and/or small group sessions [12]	44
	Peer leader/helper programs [13]	17
	Education programs for youth groups [14]	17
	Mentors [15]	18
	Preschool ATOD prevention programs [16]	2
	Drug free dances and parties [21]	45
	Youth/adult leadership activities [22]	29
	Community drop-in centers [23]	1
	Community service activities [24]	29
	Recreation activities [26]	46
	Student Assistance Programs [32]	1
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	28
	Systematic planning [42]	14
	Multi-agency coordination and collaboration/coalition [43]	28

Form 6a: Risk - Strategies (...continued)

State:

Arizona

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Economically Disadvantaged [6]	Community team-building [44]	28
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	1
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	1
	Modifying alcohol and tobacco advertising practices [53]	1
Physically Disabled [7]	Ongoing classroom and/or small group sessions [12]	1
Abuse Victims [8]	Parenting and family management [11]	1
	Mentors [15]	1
	Recreation activities [26]	2
Homeless and/or Run away Youth [10]	Parenting and family management [11]	1
	Ongoing classroom and/or small group sessions [12]	1
	Education programs for youth groups [14]	1
	Drug free dances and parties [21]	1
	Community service activities [24]	1
	Recreation activities [26]	1
	Multi-agency coordination and collaboration/coalition [43]	1
Socially Isolated Older Adults [11]	Clearinghouse/information resources centers [1]	5
	Brochures [4]	1
	Speaking engagements [6]	1
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	5
	Parenting and family management [11]	1
	Peer leader/helper programs [13]	1
	Mentors [15]	3

Form 6a: Risk - Strategies (...continued)

State:
Arizona

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Socially Isolated Older Adults [11]	Community drop-in centers [23]	3
	Recreation activities [26]	5
	Systematic planning [42]	5
	Multi-agency coordination and collaboration/coalition [43]	5
	Community team-building [44]	5

TREATMENT UTILIZATION MATRIX

State:
Arizona

Dates of State Expenditure Period:
From 7/1/2003 to 6/30/2004 (Same as Form 1)

			Costs Per Person		
Level of Care	A. Number of Admissions	B. Number of Persons Served	C. Mean Cost of Services	D. Median Cost of Services	E. Standard Deviation of Cost
Detoxification (24 hour Care)					
1. Hospital Inpatient	52	45	\$2,675.00	\$1,905.00	\$2,065.00
2. Free-standing Residential	2,494	1,966	\$1,526.00	\$1,112.00	\$1,303.00
Rehabilitation / Residential					
3. Hospital Inpatient	4,825	2,316	\$6,832.00	\$2,959.00	\$12,802.00
4. Short-term (up to 30 days)	51,066	2,658	\$4,636.00	\$2,275.00	\$7,303.00
5. Long-term (over to 30 days)	12,885	195	\$3,199.00	\$1,312.00	\$5,796.00
Ambulatory (Outpatient)					
6. Outpatient	69,341	45,420	\$1,324.00	\$592.00	\$2,945.00
7. Intensive Outpatient	4,294	2,800	\$1,639.00	\$755.00	\$2,484.00
8. Detoxification			\$0.00	\$0.00	\$0.00
Methadone	3,465	2,811	\$263.00	\$168.00	\$241.00

Form 7a Footnotes

-The method for collecting this information has changed since last year. Substance abuse treatment data is now included whether substance abuse is the primary diagnosis or secondary to another primary non-substance abuse diagnosis. In addition, more levels of care have data compared to last year. Because of the revised method of populating this Form, some clients whose primary diagnosis and treatment is not substance abuse are included and greatly influence the 'Mean Cost of Treatment' (e.g., Section II, Item 3) as well as median costs and standard deviation.

-One large region of the State did not have data entered into the client database for the period being portrayed. Consequently, all levels of care are significantly underreported.

-Figures in column A, rows 1-5, sometimes are composed of an individual, and sometimes are a tally of all services to that individual (e.g., an individual counted once who was served for 30 days versus an individual served for 30 days counted 30 times).

-Information in Levels of Care, rows 6-9, conform more to the notion of 1 person counted no matter how much continuous service they received (with the episode delineated by the '30 day no service' rule).

Number Of Persons Served (Unduplicated Count) For Alcohol And Other Drug Use In State-Funded Services By Age, Sex, And Race/Ethnicity

State:

Arizona

AGE GROUP	A. TOTAL	B. White		C. Black		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	3,757	1,719	1,187	108	46	4	1	4		333	223	77	55			1,585	1,124	660	388
2. 18-24	9,336	4,686	3,127	309	163	15	15	10	9	444	226	200	132			4,433	3,099	1,231	573
3. 25-44	29,774	14,819	10,036	1,212	673	63	34	53	28	1,312	779	428	337			15,219	10,443	2,668	1,444
4. 45-64	12,365	6,572	3,939	645	294	18	8	18	12	456	173	141	89			6,961	4,174	889	341
5. 65 and over	458	239	139	18	3			4	3	34	7	8	3			248	139	55	16
6. Total	55,690	28,035	18,428	2,292	1,179	100	58	89	52	2,579	1,408	854	616			28,446	18,979	5,503	2,762
7. Pregnant Women	448		379		14		1				42		12				369		79

Did the State base the values reported on Form 7A and 7B from a client-based system(s) with unique client identifiers?

☒ Yes ☐ No

Form 7b Footnotes

-The method for collecting this information has changed since last year. Substance abuse treatment data is now included whether substance abuse is the primary diagnosis or secondary to another primary non-substance abuse diagnosis. Consequently, youth are far more prominent than last year, and the gross tally is significantly higher.

State:
Arizona

SSA (MOE Table I)

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2003) + B2(2004) / 2 (C)
SFY 2003 (1)	\$33,610,982	
SFY 2004 (2)	\$30,941,090	\$32,276,036
SFY 2005 (3)	\$37,929,153	

Are the expenditure amounts reported in Columns B "actual" expenditures for the State fiscal years involved?

FY 2003 ☒ Yes ☐ No

FY 2004 ☒ Yes ☐ No

FY 2005 ☒ Yes ☐ No

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA(mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2005 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

☐ Yes ☒ No If yes, specify the amount

Did the State include these funds in previous year MOE calculations? ☐ Yes ☒ No

When did the State submit a request to the SAMHSA Administration to exclude these funds from the MOE calculations(Date)?

TB (MOE Table II)

State:

Arizona

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B) (C)	Average of Columns C1 and C2 C1 + C2 / 2 MOE BASE (D)
SFY 1991 (1)	\$916,654	0%	\$0	
SFY 1992 (2)	\$860,717	0%	\$0	\$0

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B)
SFY 2005 (3)	\$1,091,490	.64%	\$6,986

TB (MOE Table II) Footnotes

Statewide NON-federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment, MOE, Table II, Base and Maintenance:

Additional information had been provided by the Department's Epidemiology and Disease Control Unit, Office of Infectious Disease Control/TB Elimination Section. Calendar '95 half year data was used to develop the percentage of .64% shown for SFY '95. That percentage is the number of injection drug abusers who were in treatment for drug abuse when testing positive for t.b. (1 out of 157). On receiving that information, the same data was requested for calendar '94 and '93. No injection drug abusers were known to be in treatment for substance abuse either of those years.

Therefore, the Table derives State funds spent for SFY '95, but not for '94 or '93. For '92, substance abuse statistics were not available. In the past, the percent believed to be accurate for '93 was arbitrarily applied to '92. Since the revised percent is -0- for '93, that will also be displayed for '92. For SFY 96, 11 months data shows 11 of 253 were injection drug abusers who tested positive for t.b. However, none were known to be in s.a. treatment. State funds spent would normally be considered -0- for State Fiscal Years 96 through 2004. However, given that the data available is limited and unrefined, it would not be implausible to assume the same percentage for SFY 2004 as SFY 95. The same assumption was used to identify data for SFY 2005, except that at this writing, only calendar 2004 data is available. That info identifies 7 injection drug abusers, 31 non-injection drug abusers, and 48 excessive alcohol users who tested positive out of 272. All were known to have engaged in substance abuse within the year prior to TB diagnosis. None were known to be in substance abuse treatment. All information is derived from data of the Department's Bureau of Epidemiology and Disease Control Unit, Office of Infectious Disease Services/TB Control Section. Expended and encumbered funds displayed for FY 2005 are composed of State administration costs in the Section (\$80,990) plus contracted State dollars (\$1,010,500) spent by all County Health Departments and two Tribal Health Departments. The T.B. services are reported back to the Section as number of positives and the number of known substance abusers as part of those positives but data as to treatment status is not collected. The dollar amount for 2005, \$1,091,490 is somewhat more than the year before.

T.B.-related data is not currently collected in our Client Information System. Therefore, no dollar amounts from State treatment dollars spent through contract by the SSA are estimated as associated with T.B. services offered at provider sites.

HIV (MOE Table III)

State:
Arizona

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)	Average of Columns A1 and A2 $A1 + A2 / 2$ MOE BASE (B)
SFY1992 (1)	\$0	
SFY1993 (2)	\$0	\$0

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2005 (3)	\$0

* Provided to substance abusers at the site at which they receive substance abuse treatment

HIV (MOE Table III) Footnotes

HIV, Table III, Base, & Maintenance:

No State dollars managed by any state agency spent to provide services for substance abusers for the statutorily defined "comprehensive" HIV-early intervention services were spent at substance abuse treatment facilities during these years. Expenditure estimates originally provided in response to the 1994 Terms and Conditions were derived from "best guess" estimates of the Arizona Department of Youth Treatment and Rehabilitation, and did not conform to the statutory definitions as interpreted by CSAT. Therefore, they were not presented. Also, ADHS funding for HIV/AIDS services is federally derived (e.g., HRSA, CDC). The recent exception was in 2005 when the Governor's Office arranged for continuation of a \$1M outlay to assist in providing maintenance medications that had been provided for a number of years. There was never any particular stipulation in this funding regarding drug or alcohol abusers either in or out of treatment.

Therefore, as best can be determined, the Department of Health Services does not spend state appropriated funds on HIV/AIDS early intervention services.

Womens (MOE TABLE IV)

State:
Arizona

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

PERIOD	Total Women's BASE (A)	Total Expenditures (B)
1994	\$2,796,016	
2003		\$2,796,016
2004		\$2,796,016
2005		\$2,796,016

Enter the amount the State plans to expend in FY 2006 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): \$2,796,016

State:
Arizona

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use in deciding how to allocate FY 2006 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

- ☐ Population levels, Specify formula:

- ☐ Incidence and prevalence levels
- ☐ Problem levels as estimated by alcohol/drug-related crime statistics
- ☐ Problem levels as estimated by alcohol/drug-related health statistics
- ☐ Problem levels as estimated by social indicator data
- ☐ Problem levels as estimated by expert opinion
- 2 Resource levels as determined by (specific method)
traditional allocation by region

- 3 Size of gaps between resources (as measured by)
network analysis & claims

- and needs (as estimated by)
RBHA's & DBHS

- 1 Other (specify):
maintenance funding

Treatment Needs Assessment Summary Matrix

State:								Calendar Year:					
Arizona								2004					
1.	2.	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Sale	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Pima County	571,179	58,338	4,728	387	387	17,687	1,713	5,081	7,431	908	6	8	4
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Sale	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Yuma and La Paz Counties	111,011	10,193	704	791	545	1,699	159	557	1,174	88	4	3	25
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Sale	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Northern Arizona 5 Counties	394,886	39,089	3,272	798	798	17,334	1,407	3,719	2,674	599	7	4	3
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Sale	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Southeast Arizona	126,104	9,375	528	268	268	1,608	260	574	231	18	10	5	1

Treatment Needs Assessment Summary Matrix

State:								Calendar Year:					
Arizona								2004					
1.	2.	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Sale	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Pinal and Gila Counties	158,477	17,824	1,866	149	149	4,341	357	1,321	659	136	11	8	21

Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Sale	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Maricopa County	2,167,338	279,158	23,087	4,462	2,619	59,121	6,939	27,054	10,560	3,177	8	8	9

Treatment Needs by Age, Sex, and Race/Ethnicity

State:
Arizona

Substate Planning Area [95]:
State Total

AGE GROUP	A. TOTAL	B. WHITE		C. BLACK		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKA NATIVE		G. MORE THAN ONE RACE REPORTED		H. UNKNOWN		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2. 18 - 24	127,899	76,654	34,486	888	1,312	0	0	1,223	890	2,881	5,006	4,114	0	0	445	24,217	12,424	61,543	29,715
3. 25 - 44	238,431	182,334	41,175	5,911	1,044	0	0	1,746	1,044	1,284	2,237	0	0	941	715	35,668	8,691	156,548	37,524
4. 45 - 64	47,647	31,945	12,224	1,310	323	0	0	0	0	304	886	0	0	655	0	3,314	2,119	30,900	11,314
5. 65 and over		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Total	413,977	290,933	87,885	8,109	2,679			2,969	1,934	4,469	8,129	4,114		1,596	1,160	63,199	23,234	248,991	78,553

State:
Arizona

INTENDED USE PLAN
(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

SOURCE OF FUNDS
(24 Month Projection)

Activity (see instructions for using Row 1)	A. FY 2006 SAPT Block Grant	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance abuse treatment and rehabilitation	\$23,000,612	\$81,281,963	\$0	\$29,235,750	\$10,844,486	\$0
2. Primary Prevention	\$6,310,532		\$0	\$314,200	\$0	\$0
3. Tuberculosis Services	\$0	\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$1,577,633	\$0	\$0	\$0	\$0	\$0
5. Administration (excluding program/provider level)	\$663,886		\$0	\$0	\$181,600	\$0
6. Column Total	\$31,552,663	\$81,281,963	\$	\$29,549,950	\$11,026,086	\$

Primary Prevention Planned Expenditures Checklist

State:
Arizona

	Block Grant FY 2006	Other Federal	State	Local	Other
Information Dissemination	\$469,672	\$	\$10,000	\$	\$
Education	\$2,619,099	\$	\$95,000	\$	\$
Alternatives	\$1,312,645	\$	\$40,000	\$	\$
Problem Identification & Referral	\$51,598	\$	\$401	\$	\$
Community-Based Process	\$928,759	\$	\$500	\$	\$
Environmental	\$928,759	\$	\$500	\$	\$
Other	\$	\$	\$	\$	\$
Section 1926 - Tobacco	\$	\$	\$	\$	\$
TOTAL	\$6,310,532	\$	\$146,401	\$	\$

Planned Expenditures on Resource Development Activities

State:
Arizona

Does your State plan to fund resource development activities with FY 2006 funds?

☐ Yes ☒ No

	Treatment	Prevention	Total
Planning, Coordination and Needs Assessment	\$	\$	\$
Quality Assurance	\$	\$	\$
Training (post-employment)	\$	\$	\$
Education (pre-employment)	\$	\$	\$
Program Development	\$	\$	\$
Research and Evaluation	\$	\$	\$
Information Systems	\$	\$	\$
TOTAL	\$	\$	\$

State:

Arizona

TREATMENT CAPACITY MATRIX

This form contains data covering a 24 month projection for the period during which your principal agency of the State is permitted to spend the FY 2006 block grand award.

Level of Care	A. Number of Admissions	B. Number of Persons Served
Detoxification (24 hour Care)		
1. Hospital Inpatient	104	90
2. Free-standing Residential	4,988	3,932
Rehabilitation / Residential		
3. Hospital Inpatient	9,650	4,632
4. Short-term (up to 30 days)	102,132	5,316
5. Long-term (over to 30 days)	25,770	390
Ambulatory (Outpatient)		
6. Outpatient	138,682	90,840
7. Intensive Outpatient	8,588	5,600
8. Detoxification		
Methadone	6,930	5,622

State:
Arizona

Purchasing Services

Methods for Purchasing

This item requires completing two checklists

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2006 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

- | | |
|--|--------------------------|
| <input type="checkbox"/> Competitive grants | Percent of Expense: % |
| <input checked="" type="checkbox"/> Competitive contracts | Percent of Expense: 100% |
| <input type="checkbox"/> Non-competitive grants | Percent of Expense: % |
| <input type="checkbox"/> Non-competitive contracts | Percent of Expense: % |
| <input type="checkbox"/> Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services | Percent of Expense: % |
| <input type="checkbox"/> Other | Percent of Expense: % |

(The total for the above categories should equal 100 percent.)

- | | |
|---|-----------------------|
| <input type="checkbox"/> According to county or regional priorities | Percent of Expense: % |
|---|-----------------------|

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. In addressing a States allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

- | | |
|---|--|
| <input type="checkbox"/> Line item program budget | Percent of Clients Served: %
Percent of Expenditures: % |
| <input type="checkbox"/> Price per slot | Percent of Clients Served: %
Percent of Expenditures: % |
| Rate: | Type of slot: |
| Rate: | Type of slot: |
| Rate: | Type of slot: |
| <input checked="" type="checkbox"/> Price per unit of service | Percent of Clients Served: 100%
Percent of Expenditures: 100% |
| Unit: too numerous to list | Rate: |
| Unit: | Rate: |
| Unit: | Rate: |

PAGE 2 - Purchasing Services Checklist

☐ Per capita allocation (Formula):

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per episode of care:

Percent of Clients Served: %
Percent of Expenditures: %

Rate: Diagnostic Group:

Rate: Diagnostic Group:

Rate: Diagnostic Group:

State:
Arizona

Program Performance Monitoring

- ☒ On-site inspections
 - (Frequency for treatment:) at least annually
 - (Frequency for prevention:) at least annually
- ☒ Activity Reports
 - (Frequency for treatment:) 1/4ly for HIV services
 - (Frequency for prevention:) annually
- ☒ Management information System
- ☒ Patient/participant data reporting system
 - (Frequency for treatment:) quarterly
 - (Frequency for prevention:) see Activity Reports above
- ☐ Performance Contracts
- ☐ Cost reports
- ☒ Independent Peer Review
- ☒ Licensure standards - programs and facilities
 - (Frequency for treatment:) annually
 - (Frequency for prevention:) N/A
- ☒ Licensure standards - personnel
 - (Frequency for treatment:) annually as of January 2004
 - (Frequency for prevention:)
- ☐ Other (Specify):

State:
Arizona

Reporting Period:
From 7/1/2003 To 6/30/2004

FORM T1 - TREATMENT PERFORMANCE MEASURE EMPLOYMENT STATUS (From Admission to Discharge)

Employment Status - Clients employed (full-time or part-time) (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients employed (full-time and part-time) [numerator]			
Total number of clients with non-missing values on employment status [denominator]			
Percent of clients employed (full-time and part-time)			/

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T1.1
What is the source of data for this table? (Select all that apply)

☒ Client Self Report
☐ Administrative Data Source
☐ Other: Specify

T1.2
How is Admission/Discharge Basis defined? (Select one)

☒ Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days.
☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
☐ Other: Specify

T1.3
How was the discharge data collected? (Select all that apply)

☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
☐ In-Treatment data days post admission OR ☐ Follow-up data months
Post ☐ admission OR ☐ discharge
☐ Other: Specify

☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
☐ Discharge data is collected for a sample of all clients who were admitted to treatment
☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
☐ Discharge records are NOT completed for some clients who were admitted to treatment
Specify proportion of admitted clients with a discharge record: %

T1.4
Was the admission and discharge data linked? (Select all that apply)

☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
Select type of UCID:
☒ Master Client Index or Master Patient Index, centrally assigned
☐ Social Security Number
☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
☐ Some other Statewide unique ID
☐ Provider-entity-specific unique ID

☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
☐ No, admission and discharge records were matched using probabilistic record matching

T1.5

Why are you Unable to Report?
(Select all that apply)

- ☐ Not Applicable, data reported above
☐ Information is not collected at Admission ☐ Information is not collected at Discharge
☐ Information not collected by categories requested
☐ State collects information on the indicator area but utilizes a different measure
☒ Other: Specify Too many missing values for reliability.

State Description of Employment Status Data Collection (Form T1)

GOAL

To improve the employment status of persons treated in the States substance abuse treatment system.

MEASURE

The change in all clients receiving treatment who reported being employed (including part-time) at discharge.

STATE CONFORMANCE
TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on employment that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S)	<p>Source(s): The data is drawn using a selection procedure as follows:</p> <p>(1) All adults who completed treatment within FY 04 (e.g., admission and discharge within FY 04), excluding: crisis service only; detoxification service only; inpatient service only; assessment only; laboratory/transportation/radiology only.</p> <p>(2)a) Employment= full and part time, with or without support, and volunteer/unpaid rehabilitation activities.</p> <p>b) Homeless= homeless or shelter. Denominator does not include persons not eligible to be homeless (e.g., in a controlled environment, institution, jail or fostercare).</p> <p>c) Criminal Justice= no arrests in past 30 days, or 30 days prior if in a controlled environment.</p> <p>d) Abstinence= no use in past 30 days, or 30 days prior if in a controlled environment. Includes both primary and secondary use.</p> <p>(3) All data is collected through a single statewide assessment tool developed by DBHS.</p>
DATA ISSUES	<p>Issues: (1) Data suffers from too many missing values to be reliable. DBHS implemented a system of hard edits on 9/1/2005 as a corrective procedure.</p> <p>(2) Data includes all persons with substance abuse diagnoses in the system, including SMI adults and SED kids with secondary diagnoses.</p> <p>(3) Format and logic of some measures is questionable (e.g., abstinence to abstinence) and should be rethought. Formulas (e.g., relative change) are cumbersome and would be difficult to explain/defend before an audience.</p>

DATA PLANS IF DATA IS NOT AVAILABLE

State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

Form T1 Footnotes

Admission/discharge data with relevant employment status information suffered from gaps in the data and was not considered accurate enough for inclusion in the data table.

State:
Arizona

Reporting Period:
From 7/1/2003 To 6/30/2004

FORM T2 - TREATMENT PERFORMANCE MEASURE

HOMELESSNESS: Living Status (From Admission to Discharge)

Homelessness - Clients homeless (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients homeless [numerator]	177	167	
Total number of clients with non-missing values on living arrangements [denominator]	1,649	1,729	
Percent of clients homeless	10.73%	9.66%	-1.08% / -10.02%

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T2.1
What is the source of data for this table? (Select all that apply)

☒ Client Self Report
☐ Administrative Data Source
☐ Other: Specify

T2.2
How is Admission/Discharge Basis defined? (Select one)

☒ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
☐ Other: Specify

T2.3
How was the discharge data collected? (Select all that apply)

☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
☐ In-Treatment data days post admission OR ☐ Follow-up data months
Post ☐ admission OR ☐ discharge
☐ Other: Specify

☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
☐ Discharge data is collected for a sample of all clients who were admitted to treatment
☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
☐ Discharge records are NOT completed for some clients who were admitted to treatment
Specify proportion of admitted clients with a discharge record: %

T2.4
Was the admission and discharge data linked? (Select all that apply)

☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
Select type of UCID:
☒ Master Client Index or Master Patient Index, centrally assigned
☐ Social Security Number
☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
☐ Some other Statewide unique ID
☐ Provider-entity-specific unique ID

☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
☐ No, admission and discharge records were matched using probabilistic record matching

T2.5

Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
☐ Information is not collected at Admission ☐ Information is not collected at Discharge
☐ Information not collected by categories requested
☐ State collects information on the indicator area but utilizes a different measure
☐ Other: Specify

State Description of Homelessness (Living Status) Data Collection (Form T2)*

GOAL

To improve the living conditions of persons treated in the States substance abuse treatment system.

MEASURE

The change in all clients receiving treatment who reported being homeless at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on living status that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S)	<p>Source(s): The data is drawn using a selection procedure as follows:</p> <p>(1) All adults who completed treatment within FY 04 (e.g., admission and discharge within FY 04), excluding: crisis service only; detoxification service only; inpatient service only; assessment only; laboratory/transportation/radiology only.</p> <p>(2)a) Employment= full and part time, with or without support, and volunteer/unpaid rehabilitation activities.</p> <p>b) Homeless= homeless or shelter. Denominator does not include persons not eligible to be homeless (e.g., in a controlled environment, institution, jail or fostercare).</p> <p>c) Criminal Justice= no arrests in past 30 days, or 30 days prior if in a controlled environment.</p> <p>d) Abstinence= no use in past 30 days, or 30 days prior if in a controlled environment. Includes both primary and secondary use.</p> <p>(3) All data is collected through a single statewide assessment tool developed by DBHS.</p>
DATA ISSUES	<p>Issues: (1) Data suffers from too many missing values to be reliable. DBHS implemented a system of hard edits on 9/1/2005 as a corrective procedure.</p> <p>(2) Data includes all persons with substance abuse diagnoses in the system, including SMI adults and SED kids with secondary diagnoses.</p> <p>(3) Format and logic of some measures is questionable (e.g., abstinence to abstinence) and should be rethought. Formulas (e.g., relative change) are cumbersome and would be difficult to explain/defend before an audience.</p>
DATA PLANS IF DATA IS NOT AVAILABLE	<p>State should provide time-framed plans for capturing living status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.</p>

State:
Arizona

Reporting Period:
From 7/1/2003 To 6/30/2004

FORM T3 - TREATMENT PERFORMANCE MEASURE CRIMINAL JUSTICE INVOLVEMENT (From Admission to Discharge)

Arrests - Clients arrested (any charge) (in prior 30 days) at admission vs. discharge - T3	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of Clients arrested [numerator]	934	706	
Total number of clients with non-missing values on arrests [denominator]	2,980	2,857	
Percent of clients arrested	31.34%	24.71%	-6.63% / -21.16%

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T3.1
What is the source of data for this table? (Select all that apply)

☒ Client Self Report
☐ Administrative Data Source
☐ Other: Specify

T3.2
How is Admission/Discharge Basis defined? (Select one)

☒ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
☐ Other: Specify

T3.3
How was the discharge data collected? (Select all that apply)

☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
☐ In-Treatment data days post admission OR ☐ Follow-up data months
Post ☐ admission OR ☐ discharge
☐ Other: Specify

☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
☐ Discharge data is collected for a sample of all clients who were admitted to treatment
☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
☐ Discharge records are NOT completed for some clients who were admitted to treatment
Specify proportion of admitted clients with a discharge record: %

T3.4
Was the admission and discharge data linked? (Select all that apply)

☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
Select type of UCID:
☒ Master Client Index or Master Patient Index, centrally assigned
☐ Social Security Number
☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
☐ Some other Statewide unique ID
☐ Provider-entity-specific unique ID

☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
☐ No, admission and discharge records were matched using probabilistic record matching

T3.5

Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
☐ Information is not collected at Admission ☐ Information is not collected at Discharge
☐ Information not collected by categories requested
☐ State collects information on the indicator area but utilizes a different measure
☐ Other: Specify

State Description of Number of Arrests Data Collection (Form T3)

GOAL

To reduce the criminal justice involvement of persons treated in the States substance abuse treatment system.

MEASURE

The change in persons arrested in the last 30 days at discharge for all clients receiving treatment.

STATE CONFORMANCE
TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on criminal justice involvement that can be reported as a Yes/No response.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S)	<p>Source(s): The data is drawn using a selection procedure as follows:</p> <ul style="list-style-type: none"> (1) All adults who completed treatment within FY 04 (e.g., admission and discharge within FY 04), excluding: crisis service only; detoxification service only; inpatient service only; assessment only; laboratory/transportation/radiology only. (2)a) Employment= full and part time, with or without support, and volunteer/unpaid rehabilitation activities. b) Homeless= homeless or shelter. Denominator does not include persons not eligible to be homeless (e.g., in a controlled environment, institution, jail or fostercare). c) Criminal Justice= no arrests in past 30 days, or 30 days prior if in a controlled environment. d) Abstinence= no use in past 30 days, or 30 days prior if in a controlled environment. Includes both primary and secondary use. (3) All data is collected through a single statewide assessment tool developed by DBHS.
DATA ISSUES	<p>Issues: States will need to discuss if information on all arrests is not available.</p> <ul style="list-style-type: none"> (1) Data suffers from too many missing values to be reliable. DBHS implemented a system of hard edits on 9/1/2005 as a corrective procedure. (2) Data includes all persons with substance abuse diagnoses in the system, including SMI adults and SED kids with secondary diagnoses. (3) Format and logic of some measures is questionable (e.g., abstinence to abstinence) and should be rethought. Formulas (e.g., relative change) are cumbersome and would be difficult to explain/defend before an audience.
DATA PLANS IF DATA IS NOT AVAILABLE	<p>State should provide time-framed plans for capturing arrest data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.</p>

State:
Arizona

Reporting Period:
From 7/1/2003 To 6/30/2004

FORM T4 - PERFORMANCE MEASURE
CHANGE IN ABSTINENCE - ALCOHOL USE (From Admission to Discharge)

Alcohol Abstinence - Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients abstinent from alcohol [numerator]	872	891	
Total number of clients with non-missing values on 'used any alcohol' variable [denominator]	1,835	1,749	
Percent of clients abstinent from alcohol	47.52%	50.94%	3.42% / 7.20%

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE**T4.1**

What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report confirmed by another source.--> If checked, select one confirmation source.
☐ Client Self Report ☐ Urinalysis, blood test or other biological assay
☐ Administrative Data Source ☐ Collateral source
☒ Other: Specify Clinician judgement, or scale. ☐ Other: Specify

T4.2

How is Admission/Discharge Basis defined? (Select one)

- ☒ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
☐ Other: Specify

T4.3

How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
☐ In-Treatment data days post admission OR ☐ Follow-up data months
 Post ☐ admission OR ☐ discharge
☐ Other: Specify
☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
☐ Discharge data is collected for a sample of all clients who were admitted to treatment
☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
☐ Discharge records are NOT completed for some clients who were admitted to treatment
 Specify proportion of admitted clients with a discharge record: %

T4.4

Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
 Select type of UCID:
☒ Master Client Index or Master Patient Index, centrally assigned
☐ Social Security Number
☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
☐ Some other Statewide unique ID
☐ Provider-entity-specific unique ID
☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
☐ No, admission and discharge records were matched using probabilistic record matching

T4.5

Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
☐ Information is not collected at Admission ☐ Information is not collected at Discharge
☐ Information not collected by categories requested
☐ State collects information on the indicator area but utilizes a different measure
☐ Other: Specify

State Description of Alcohol Use Data Collection (Form T4)**GOAL**

To reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change of all clients receiving treatment who reported abstinence at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on alcohol use that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S)	<p>Source(s): The data is drawn using a selection procedure as follows:</p> <p>(1) All adults who completed treatment within FY 04 (e.g., admission and discharge within FY 04), excluding: crisis service only; detoxification service only; inpatient service only; assessment only; laboratory/transportation/radiology only.</p> <p>(2)a) Employment= full and part time, with or without support, and volunteer/unpaid rehabilitation activities.</p> <p>b) Homeless= homeless or shelter. Denominator does not include persons not eligible to be homeless (e.g., in a controlled environment, institution, jail or fostercare).</p> <p>c) Criminal Justice= no arrests in past 30 days, or 30 days prior if in a controlled environment.</p> <p>d) Abstinence= no use in past 30 days, or 30 days prior if in a controlled environment. Includes both primary and secondary use.</p> <p>(3) All data is collected through a single statewide assessment tool developed by DBHS.</p>
DATA ISSUES	<p>Issues: (1) Data suffers from too many missing values to be reliable. DBHS implemented a system of hard edits on 9/1/2005 as a corrective procedure.</p> <p>(2) Data includes all persons with substance abuse diagnoses in the system, including SMI adults and SED kids with secondary diagnoses.</p> <p>(3) Format and logic of some measures is questionable (e.g., abstinence to abstinence) and should be rethought. Formulas (e.g., relative change) are cumbersome and would be difficult to explain/defend before an audience.</p>
DATA PLANS IF DATA IS NOT AVAILABLE	<p>State should provide time-framed plans for capturing alcohol use data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.</p>

State:
Arizona

Reporting Period:
From 7/1/2003 To 6/30/2004

FORM T5 - PERFORMANCE MEASURE
CHANGE IN ABSTINENCE - OTHER DRUG USE (From Admission to Discharge)

Drug Abstinence - Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients abstinent from illegal drugs [numerator]	350	358	
Total number of clients with non-missing values on 'used any drug' variable [denominator]	840	830	
Percent of clients abstinent from drugs	41.67%	43.13%	1.47% / 3.52%

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE**T5.1**

What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report confirmed by another source.--> If checked, select one confirmation source.
☐ Client Self Report ☐ Urinalysis, blood test or other biological assay
☐ Administrative Data Source ☐ Collateral source
☒ Other: Specify Clinician judgement, or scale. ☐ Other: Specify

T5.2

How is Admission/Discharge Basis defined? (Select one)

- ☒ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
☐ Other: Specify

T5.3

How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
☐ In-Treatment data days post admission OR ☐ Follow-up data months
 Post ☐ admission OR ☐ discharge
☐ Other: Specify
☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
☐ Discharge data is collected for a sample of all clients who were admitted to treatment
☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
☐ Discharge records are NOT completed for some clients who were admitted to treatment
 Specify proportion of admitted clients with a discharge record: %

T5.4

Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
 Select type of UCID:
☒ Master Client Index or Master Patient Index, centrally assigned
☐ Social Security Number
☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
☐ Some other Statewide unique ID
☐ Provider-entity-specific unique ID
☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
☐ No, admission and discharge records were matched using probabilistic record matching

T5.5

Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
☐ Information is not collected at Admission ☐ Information is not collected at Discharge
☐ Information not collected by categories requested
☐ State collects information on the indicator area but utilizes a different measure
☐ Other: Specify

State Description of Other Drug Use Data Collection (Form T5)

GOAL

To reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change in all clients receiving treatment who reported abstinence at discharge.

STATE CONFORMANCE
TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on other drug use that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S)	<p>Source(s): The data is drawn using a selection procedure as follows:</p> <p>(1) All adults who completed treatment within FY 04 (e.g., admission and discharge within FY 04), excluding: crisis service only; detoxification service only; inpatient service only; assessment only; laboratory/transportation/radiology only.</p> <p>(2)a) Employment= full and part time, with or without support, and volunteer/unpaid rehabilitation activities.</p> <p>b) Homeless= homeless or shelter. Denominator does not include persons not eligible to be homeless (e.g., in a controlled environment, institution, jail or fostercare).</p> <p>c) Criminal Justice= no arrests in past 30 days, or 30 days prior if in a controlled environment.</p> <p>d) Abstinence= no use in past 30 days, or 30 days prior if in a controlled environment. Includes both primary and secondary use.</p> <p>(3) All data is collected through a single statewide assessment tool developed by DBHS.</p>
DATA ISSUES	<p>Issues: (1) Data suffers from too many missing values to be reliable. DBHS implemented a system of hard edits on 9/1/2005 as a corrective procedure.</p> <p>(2) Data includes all persons with substance abuse diagnoses in the system, including SMI adults and SED kids with secondary diagnoses.</p> <p>(3) Format and logic of some measures is questionable (e.g., abstinence to abstinence) and should be rethought. Formulas (e.g., relative change) are cumbersome and would be difficult to explain/defend before an audience.</p>
DATA PLANS IF DATA IS NOT AVAILABLE	<p>State should provide time-framed plans for capturing other drug use data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.</p>

Form T6

State:
Arizona

Voluntary Form T6 - Infectious Diseases Performance Measure

This goal of this form is to determine the degree to which the Single State Agency provides and/or coordinates delivery of appropriate infection control practices within its service system for substance abuse treatment and prevention services. This form is a checklist to be completed by the Single State Agency (SSA). For each item, please check the box that best relates the degree to which that item describes the State Infectious Disease control program/practices. The SSA should develop a method for self-assessment to examine its policies, procedures and services relevant to infectious disease control. The SSA should attempt to use the same self-assessment criteria from year to year. The SSA should perform this assessment annually.

LEGEND: 0-Not addressed; 1-Inadequately addressed; 2-Adequately addressed; and 3-Completely addressed
(Select one for each response to questions 1-8)

CHARACTERISTICS DOCUMENTING APPROPRIATE PRACTICES IN INFECTIOUS DISEASES CONTROL

0 1 2 3

- ☐ ☐ ☐ ☒ 1. Single State Agency (SSA) maintains Memoranda of Understanding (MOU) and/or other formal arrangements with appropriate public health agencies and other social service providers to provide continuum of care for persons with substance use disorders who are also at risk for infectious diseases including screening, assessment, referral and treatment for infectious diseases and preventive practices to control disease transmission.

Specify MOUs and other formal agreements maintained:

Have MOU with the Office of HIV, and the State Laboratory (both within ADHS) since 2000.

0 1 2 3

- ☐ ☐ ☒ ☐ 2. Single State Agency (SSA) or other State agency certification, licensure or contract provisions require infectious disease control procedure/policies (infectious disease control standards) at the provider level.

Single State Agency or other State agency monitors provider implementation of policies/procedures.

Specify licensure; certification; or contract provision(s)

Licensure provisions:

The Office of Behavioral Health Licensure within the Arizona Department of Health Services licenses all behavioral health treatment agencies in Arizona. It prepares Rules to set the standards for licensing agencies. These Rules are part of the Arizona Administrative Code, Title 9, and the behavioral health rules are at 9-20-101 through 9-20-1508, where specific language relevant to this question can be found.

Specify authority administering licensure; certification; or contract process

The Office of Behavioral Health Licensure within the ADHS has the authority to apply the standards embodied in Rule.

Specify monitoring activity(ies)

The Office of Behavioral Health Licensure makes yearly site visits to provider agencies to see if the Rules are being practiced.

The Division of Behavioral Health Services also conducts annual visits to contractors and SAPT Block Grant requirements are part of the items reviewed.

Specify proportion of programs meeting or exceeding infectious disease control standards during compliance monitoring

%

CHARACTERISTICS OF HUMAN IMMUNODEFICIENCY VIRUS AND TUBERCULOSIS CONTROL ACTIVITY

YES NO

☒

☐

Is the State a 'designated State' (i.e., cumulative case rate is equal to or greater than 10/100,000)?

YES NO

☒

☐

Was the State a 'designated State' (i.e., cumulative case rate is equal to or greater than 10/100,000) in at least one of the last two years?

YES NO

☒

☐

If the State is a designated State, have HIV infection procedures been developed by the principal agency for substance abuse in consultation with the State Medical Director and in cooperation with the State Department of Health/Communicable Disease Officer?

Whether or not the State is a 'designated State':

0 1 2 3

☐ ☐ ☐ ☒ 3.

Are early intervention services(EIS) projects provided at the site where individuals are undergoing substance abuse treatment?

Specify the number of substance abuse treatment sites providing EIS:

45

If the State funds more than one EIS project, specify number of such substance abuse treatment sites that are located in a rural area(s):

12

0 1 2 3

☐ ☐ ☒ ☐ 4.

Do these sites have established linkages with a comprehensive community resource network of related health and social service organizations?

0 1 2 3

☐ ☐ ☐ ☒ 5.

Do State funded substance abuse programs provide on-site or through referral:

(A) Appropriate pre-test and post-test counseling for HIV and AIDS;

(B) testing individuals with respect to such disease, including tests to diagnose the extent of the deficiency, tests to provide information on appropriate therapeutic measures, and for preventing and treating conditions arising from the disease; and

(C) providing the therapeutic measures described in (B).

0 1 2 3

☐ ☐ ☒ ☐ 6.

Are tuberculosis services as described in 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.121 and 96.127, routinely made available, directly or through arrangement with other public or nonprofit private entities, to each individual receiving substance abuse treatment services?

0 1 2 3

- ☐ ☐ ☒ ☐ 7. Have infection control procedures as described in 45 C.F.R. 96.127(a)(3) been established by the principal agency of the State for substance abuse, in cooperation with the State Medical Director and in cooperation with the State Department of Health/Tuberculosis Control Officer that which are designed to prevent the transmission of tuberculosis?

Specify the proportion of sites providing screening services directly or through referral:

100%

Specify the proportion of sites providing case management activities as described in 45 C.F.R. 96.127(a)(4) of clients with TB to ensure that individuals receive necessary services:

%

0 1 2 3

- ☐ ☐ ☒ ☐ 8. Have effective strategies been developed for monitoring programs compliance with 45 C.F.R. 96.121 and 96.127?

Specify the procedures utilized:

- 1) Annual site visits to State contractors/TRBHAs to review compliance with Block Grant requirements (conducted by the Division of Behavioral Health Services).
- 2) Annual visits by the Office of Behavioral Health Licensure to test compliance with Rules.

YES NO

☒ ☐ Licensure or program certification standards

YES NO

☐ ☒ Contract or grant specifications/requirements

YES NO

☐ ☒ On-site monitoring

YES NO

☐ ☒ Client records audits

Total: 19

Total the numbers in the boxes (possible 0-24) and enter the number in the total cell.

State:
Arizona

Reporting Period:
From To

FORM T7 - PERFORMANCE MEASURE CHANGE IN SOCIAL SUPPORT OF RECOVERY (From Admission to Discharge)

Social Support of Recovery - Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	0	0	
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	0	0	
Percent of clients participating in social support activities			0.00% / 0.00%

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T7.1
What is the source of data for this table? (Select all that apply)

☐ Client Self Report
☐ Administrative Data Source
☐ Other: Specify

T7.2
How is Admission/Discharge Basis defined? (Select one)

☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days.
☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
☐ Other: Specify

T7.3
How was the discharge data collected? (Select all that apply)

☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
☐ In-Treatment data days post admission OR ☐ Follow-up data months
Post ☐ admission OR ☐ discharge
☐ Other: Specify

☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
☐ Discharge data is collected for a sample of all clients who were admitted to treatment
☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
☐ Discharge records are NOT completed for some clients who were admitted to treatment
Specify proportion of admitted clients with a discharge record: %

T7.4
Was the admission and discharge data linked? (Select all that apply)

☐ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
Select type of UCID:
☐ Master Client Index or Master Patient Index, centrally assigned
☐ Social Security Number
☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
☐ Some other Statewide unique ID
☐ Provider-entity-specific unique ID

☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
☐ No, admission and discharge records were matched using probabilistic record matching

T7.5

Why are you Unable to Report?
(Select all that apply)

- ☐ Not Applicable, data reported above
☒ Information is not collected at Admission
☒ Information is not collected at Discharge
☐ Information not collected by categories requested
☐ State collects information on the indicator area but utilizes a different measure
☐ Other: Specify

State Description of Social Support of Recovery Data Collection (Form T7)

GOAL

To improve clients' participation in social support of recovery activities to reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change in all clients receiving treatment who reported participation in one or more social and or recovery support activity at discharge.

**STATE CONFORMANCE
TO INTERIM STANDARD**

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission and discharge data on social support of recovery that can be reported using definitions provided as follows:

Participation in social support of recovery activities are defined as attending self-help, attending religious/faith affiliated recovery or self help groups, attending meetings of organizations other than the organizations described above or interactions with family members and/or friends supportive of recovery.

YES ☐ NO ☒

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S)

Source(s):

DATA ISSUES

Issues: Self help and support group attendance is not incorporated in the Client Information System database.

DATA PLANS IF DATA IS NOT AVAILABLE

State should provide time-framed plans for capturing social support of recovery data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

State:
Arizona

FORM T8: RETENTION

Length of Stay (in Days) of Clients Completing Treatment

Length of Stay			
LEVEL OF CARE	AVERAGE	MEDIAN	STANDARD DEVIATION
DETOXIFICATION (24 HOUR CARE)			
1. Hospital Inpatient	5	5	2.82
2. Free-standing Residential	5	4	3.08
REHABILITATION / RESIDENTIAL			
3. Hospital Inpatient	17	7	33.9
4. Short-term (up to 30 days)	28	14	39.77
5. Long-term (over 30 days)	88	49	86.86
AMBULATORY (OUTPATIENT)			
6. Outpatient	24	11	40.82
7. Intensive Outpatient	20	11	29.21
8. Detoxification	0	0	0
9. Methadone	87	56	75.05

State:
Arizona

Reporting Period:
From 7/1/2003 To 6/30/2004

Prevention Form P1

NUMBER OF PERSONS SERVED

Persons served in Block Grant funded services include all persons served in prevention programs that receive all or part of their funding through the SAPT Block Grant.

AGE	TOTAL	SINGLE SERVICES	RECURRING SERVICES	RACE/ETHNICITY	TOTAL	SINGLE SERVICES	RECURRING SERVICES	GENDER	TOTAL	SINGLE SERVICES	RECURRING SERVICES
0-4	6041	3558	2483	American Indian / Alaska Native	22326	15896	6430	MALE	102361	63315	39046
5-11	88831	52318	36513	Asian	2562	1306	1256	FEMALE	116275	63315	52960
12-14	43925	25870	18055	Black / African American	15859	9718	6141				
15-17	14653	8630	6023	Native Hawaiian / Other Pacific Islander	0	0	0				
18-20	3975	2341	1634	White	59907	31990	27917				
21-24	10493	6180	4313	More than one Race	7335	5980	1355				
25-44	28214	16617	11597	Unknown	27539	21502	7080				
45-64	7800	4594	3206	Total	135528	86392	50179				
65+	11072	6521	4551	Not Hispanic Or Latino	0	0	0				
				Hispanic Or Latino	82065	40238	41827				
Total	215004	126629	88375	Total	82065	40238	41827	Total	218636	126630	92006

Form P1 Footnotes

Hispanic data has been collected as if Hispanic/Latino is a 'race' rather than an ethnic group. That is why it is not portrayed as an overlay on all races shown. In the future, the process for collecting this data will be modified. For now, the addition of the 'Hispanic/Latino figures to the Total will give the gross number of individuals served.

State:
Arizona

Reporting Period:
From 7/1/2003 To 6/30/2004

PREVENTION FORM P2

NUMBER OF EVIDENCE-BASED PROGRAMS, PRACTICES, POLICIES, AND STRATEGIES

Programs include all prevention programs, practices, policies, and strategies
that receive all or part of their funding through the SAPT Block Grant.

1.NREPP effective programs or practices (such as Project Northland or Life Skills) below.

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total
Incredible Years	1	0	0	1
Life Skills Training	3	4	0	7
Across Ages	2	0	0	2
Communities That Care	1	0	0	1
Creating Lasting Family Connections	1	0	0	1
Dare to Be You	1	0	0	1
Families and Schools Together	2	0	0	2
Paths	2	0	0	2
Preparing for the Drug Free Years	1	0	0	1
Project Alert	3	1	1	5
Project Success	0	0	1	1
Project Toward No Tobacco	1	0	0	1
Reconnecting Youth	0	0	1	1
Resolving Conflict Creatively	1	0	0	1
Second Step	13	0	1	14
Strengthening Families	5	0	0	5

2.NREPP conditionally-effective programs or practices (such as Reducing the Risk or FAN club) below.

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total
Get Real About AIDS	1	0	0	1
Popular Opinion Leader	0	1	0	1

3.NREPP emerging programs or practices (such as Focus on Kids or Brain Power) below.

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total
Get Real About Violence Prevention	2	0	0	2

4.NREPP programs or practices of interest.

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total
---------------------------	----------------------	-----------------------	-----------------------	-------

5. Peer-reviewed journal-evidenced programs, practices, policies, and strategies.

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total
Postponing Sexual Involvement	1	0	0	1

6.Names and sources of other evidence-based programs, practices, policies, strategies; attach source and type of evidence.

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total
Reducing the Risk	1	0	0	1
Big Brothers Big Sisters	0	2	0	2
Discover: SKills for Life	3	0	0	3
Growing Healthy	1	0	0	1
MELD	0	0	3	3
Nurturing Program	0	0	1	1
Parents Anonymous Group Model	0	0	1	1
Parents Who Care	0	0	2	2
STEP	1	0	0	1

7.Names and sources of other non-evidence-based programs, practices, policies and strategies; attach additional information on the program, practice, policy or

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total
A Peer Education Program for Inhalent Abuse Among Hispanic Youth	0	1	0	1
Active Parenting Today	2	0	1	3
Adolescent Pregnancy and Parenting Program	1	0	0	1
Age Alert	0	1	0	1
Alzheimers Support Group	0	0	1	1
Anger Management	1	0	0	1
Baby Think It Over	1	0	0	1
Beyond Prevention	1	0	0	1
BreakAway	1	0	0	1
CHAMPS	1	0	0	1
TOPS	2	0	0	2
Character Counts	4	1	0	5
Chemical Awareness Institute	1	0	0	1
Common Sense Parenting	0	2	0	2
Conquering Depression	1	0	0	1
Constructing Self Esteem	1	0	0	1

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total
Cultural Pride Linking Communities	0	1	0	1
Discipline with Love and Logic	4	0	1	5
Effective Black Parenting	1	0	0	1
Enjoying Life	1	0	0	1
Family Support Group	1	0	0	1
Finding Hidden Talent	1	0	0	1
First Steps	0	0	1	1
Getting Along	0	0	1	1
Girl Talk	1	0	0	1
Grand Parents Support Group	0	1	0	1
Grappeling with Grief and Loss	0	1	0	1
Guy Talk	1	0	0	1
Health Realization	2	0	0	2
Healthy Families	0	0	1	1
Healthy Living	1	0	0	1
In My House	1	0	0	1

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total
Life Planning Education	1	0	0	1
Los Ninos Bien Educados	1	0	0	1
Maricopa Tobacco Use Prevention	1	0	0	1
Motherread	1	0	0	1
PARTS	1	0	0	1
Pasos Adelante	0	0	1	1
Peer Mediation	1	0	0	1
Peer Tutoring	1	0	0	1
Peers	1	0	0	1
Positive Paths	2	0	0	2
Project Know	1	0	0	1
QPR Gatekeepers Training	1	0	0	1
QPR Suicide Traige Training	1	0	0	1
Recording Memories	1	0	0	1
Smart Girls	1	0	0	1
Smart moves	1	1	0	2

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total
Soy Unica	1	0	0	1
Strengthening Multi-Ethnic Families	0	1	1	2
Suicide Prevention Education	1	0	0	1
Tackling Stress Reduction	1	0	0	1
Teen Talk	0	1	0	1
The Technology of Development	1	0	0	1
Tools for Memory Retention	1	0	0	1
Using Positive Thinking	1	0	0	1
Wait 4 Sex	1	0	0	1
Wise Guys	0	1	0	1
Young Women Making A Difference	1	0	0	1
Youth Advocates Leadership Manual	4	0	0	4

TOTALS

GRAND TOTAL all programs	145
Percent Evidence-Based (sections 1 - 6 above)	46%
Percent Non-Evidence-Based (section 7 above)	54%

GOAL # 1. -- The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2003 (COMPLIANCE):

Organization

The Arizona Department of Health Services (ADHS) is the state agency responsible for public health education, prevention and treatment. In this capacity, ADHS serves as the Single State Authority (SSA) for the Substance Abuse Performance Partnership Block Grant. ADHS is comprised of several major divisions, the largest of which is the Division of Behavioral Health Services (DBHS). DBHS was established by Arizona Revised Statutes (§ARS 36-3402) as the permanent authority for publicly funded behavioral health services in the state. DBHS is mandated to plan, administer and monitor a comprehensive, regionalized system of prevention, intervention and treatment services for individuals and families. Behavioral health services are inclusive of treatment services and supports for mental health and substance abuse conditions, as well as primary prevention programs for persons not in need of treatment.

ADHS and DBHS interact with other state agencies through strategic partnerships to improve service delivery for shared clients, including children and adults in the correctional, criminal justice, primary and public health care, education, child welfare and developmental disability systems. ADHS also serves as the behavioral health carve-out for Medicaid funded behavioral health services through a contract with the Arizona Health Care Cost Containment System (AHCCCS). For the purposes of coordination of the SAPT Block Grant, ADHS serves on a cabinet-level planning body chaired by the Governor (see Planning Councils).

ADHS/DBHS contracts with regional organizations to administer integrated managed care delivery systems in specific geographic service areas (Regional Behavioral Health Authorities, or RBHAs). RBHAs are responsible for planning, contracting, monitoring and delivery of substance abuse treatment and prevention services within their region. For FY 2003 Compliance, regional managed care vendors for SAPT-funded substance abuse services included five RBHAs. Gila River Tribal RBHA began SAPT-funded services in FY 2004. The remaining 17 tribal communities are served through the RBHA system.

GSA	Service Area (County)	Vendor
#3	Graham, Greenlee, Santa Cruz, Cochise	Community Partnership of So. Az.
#6	Maricopa	Value Options
#5	Pima	Community Partnership of So. Az.
#1	Coconino, Apache, Navajo, Mohave	
	Yavapai	Northern Az. Reg. Behavioral Health
#4	Pinal, Gila	Pinal Gila Behavioral Health

Within the ADHS/DBHS, the Bureau for Substance Abuse Treatment and Prevention Services (BSTAP) is responsible for fiscal and programmatic oversight, monitoring and technical assistance/training for substance abuse service delivery, including compliance requirements of the SAPT Block Grant.

Funding/Eligibility Groups

ADHS/DBHS administers a unified behavioral health system using funds from various federal, state and local sources including:

- The state Medicaid agency (Arizona Health Care Cost Containment System, or AHCCCS) contracts with ADHS to administer the behavioral health benefit package for Title XIX and Title XXI acute care members.
- ADHS/DBHS administers Non-TXIX treatment services and prevention programs funded through the Substance Abuse Prevention and Treatment Block Grant and associated state appropriated funds.
- ADHS/DBHS administers other Non-Title XIX state and local funding for substance abuse services including:
 - Funds from Maricopa County and the City of Phoenix to maintain and operate substance abuse crisis stabilization and detoxification services including ambulance patrol.
 - Funds from the Arizona Department of Corrections to provide expedited access to substance abuse treatment for offenders leaving prison and re-entering the community through the Correctional Officer/Offender Liaison (COOL) program. In Maricopa County, the COOL program includes temporary housing.
 - For the year ending June 30, 2003, State Incentive Grant funds for exemplary prevention programs through an agreement with the Arizona Office of the Governor.

Title XIX/XXI members are entitled to all medically necessary substance abuse and behavioral health services. Non-Title XIX/XXI members, funded through the SAPT block grant, state appropriations and local resources, receive all medically necessary covered services based on available funding and priority population status (e.g. pregnant women).

Services

ADHS/DBHS administers a comprehensive menu of covered services for treatment, support/preventive care and emergency and crisis response. All covered services are available to individuals and families with substance abuse conditions, based on Title XIX/XXI eligibility and available funding for Non-Title XIX members.

<u>Covered Service Category</u>	<u>Covered Procedures/Services</u>
Treatment Services	Individual, Family, Group Counseling Consultation, Assessment, Special Testing Other (auricular acupuncture, traditional healers)

Rehabilitative Services	Living Skills Training, Cognitive Rehab, Health Promotion, Supported Employment
Medical Services	Medication, Methadone/LAAM Lab, Radiology, Medical Imaging Medical Management (Nursing Services) ECT
Support Services	Case Management, Personal Assistance Family Support, Peer Support Therapeutic Foster Care, Respite Care Housing Support, Transportation Interpreter Services, Flex Fund Services
Crisis Intervention	Mobil Crisis Teams Telephone Crisis Crisis Services (professional)
Inpatient Services	Hospital Level 1 Subacute (psychiatric, detoxification) Level 1 Residential Treatment Center (Children)
Residential Services	Level II, III Behavioral Health Residential Room and Board
Behavioral Health Day Programs	Supervised, Therapeutic, Medical Day
Prevention	Services for persons who do not need treatment HIV Early Intervention Services

Providers

ADHS/DBHS requires that behavioral health provider agencies be appropriately licensed for behavioral health service delivery and registered with AHCCCS to deliver services for the TXIX/XXI member population. Provider types include Level 1 inpatient/subacute, residential facilities and outpatient clinics. Behavioral health services may not be billed through halfway houses and recovery homes, although such facilities may subcontract as providers of Supported Housing. A special provider type, Rural Substance Abuse Transitional Center, provides social model crisis support with referrals to local acute care hospitals for intoxicated persons in areas defined as “rural” according to the U.S. Census. The TXIX/XXI program covers this service. A second special provider type -- Community Service Agency (CSA) -- is an organization certified by ADHS/DBHS and registered directly with AHCCCS in lieu of a behavioral health license. CSAs deliver family/peer supports, respite and other support services based upon referrals from a

member's treatment team. Prevention programs are delivered both through licensed behavioral health agencies, CSAs and other community organizations.

State Level Continuum of Care

Arizona is challenged by the diversity of its regions and peoples in delivering substance abuse services. Areas such as Phoenix, Tucson, Yuma, Prescott and Flagstaff are among the fastest growing population centers in the U.S. today, while the vast majority of state land continues to be isolated, rural communities with insignificant growth rates and large stretches of national forest and reservation lands. Geographic accessibility to services and retention of a qualified treatment workforce are major gaps in the continuum within Arizona's rural regions. An additional statewide challenge is posed by the rapid growth of the Hispanic population eligible for Medicaid and S-CHIP services: the statewide Hispanic population eligible for Medicaid is 42.4% and 19.2% are enrolled. Access to a bilingual, bicultural workforce will pose one of the greatest challenges to the state behavioral health system over the next 10 years.

Within ADHS/DBHS, the Bureau for Substance Abuse Treatment and Prevention Services (BSATP) has a reputation for pro-active involvement in reducing barriers to care and improving the quality of substance abuse treatment services available to citizens of Arizona. The BSATP has launched several system improvement initiatives designed to build capacity of critical treatment and recovery support services. Since 1999, the BSATP has worked collaboratively with mental health providers to improve delivery of services for persons with co-occurring disorders. During 2004, this initiative was extended into the criminal justice system through Arizona's participation in the National Policy Academy on Co-Occurring Disorders. The BSATP initiated a review of the statewide continuum of detoxification services in 2003 that continues as a state network development priority. Finally, the BSATP launched several pilots during 2004 to develop Peer Support services in substance abuse treatment settings across the state and to establish recovery-focused transitional housing with supports as an alternative to residential substance abuse treatment. While initial results are encouraging, availability of Peer Support workers and Supported Housing for substance abuse consumers remains a critical recovery gap.

Finally, methamphetamine emerged as the second leading cause of admissions to substance abuse treatment after alcohol: between 2002 and 2004, methamphetamine rose from 11% to 24% of all admissions for treatment. Major trends in methamphetamine abuse within the state include:

- Methamphetamine is the single most common substance reported at treatment admission among parents referred by child protective services. In 2003-2004, 40% of all referred parents reported methamphetamine as their primary drug problem.
- Proportionately, use of methamphetamine among CPS parents is higher in more rural areas of the state: 47-76% of all admissions in rural regions, compared with 28-40% in urban settings).
- Women and adolescent girls use methamphetamine at the same levels as men and adolescent boys.
- Youth and young adults age 12-24 comprised 53% of statewide treatment admissions for methamphetamine in 2003.

- Reservation communities are particularly hard hit.

In response, the BSATP is launching an initiative to establish methamphetamine “centers for excellence” in three regions during FY 2006. The centers will utilize one or more treatment approaches with demonstrated efficacy in addressing stimulant use disorders and will include simple fidelity measurements for key elements, including contingency management processes, therapeutic alliance and urine testing. In addition, BSATP has provided direct funding and technical assistance to several tribal nations, including Hopi Tribe and Navajo Nation, to address methamphetamine abuse in Arizona’s reservation communities.

Local Continuum Of Care

The Community Partnership of Southern Arizona (CPSA) serves Pima County (Tucson) and rural southeastern Arizona. The CPSA region has 28 Level I medical detoxification beds (16 in Tucson and 12 in Benson); 100 Level II substance abuse residential beds in Pima and 0 in southeastern Arizona. Forty of the Tucson beds are specialized for women with children. As part of the BSATP detoxification expansion initiative, a Level II substance abuse stabilization facility will open in Benson during 2005-2006, providing acute care services for the four counties of southeastern Arizona. CPSA contracts for 625 methadone slots in the Tucson area and provides buprenorphine in the four counties of southeastern Arizona. Outpatient assessment and counseling services are delivered through three adult providers with 16 treatment sites in Pima County and one provider with eight service sites in southeastern Arizona. Childcare services are provided by two agencies. Specialized case management and outpatient services to pregnant women in Pima County are available through Mother-Child Addiction Services (MCAS), as are family education groups and prevention for children while parents are in treatment. COOL funding covers only outpatient services. CPSA has prioritized development of co-occurring competent and enhanced programs, such that all network providers are either DDC or DDE. HIV Early Intervention Services are delivered through a single mobile contractor in Pima County and a single network serving outpatient sites in all four counties of southeastern Arizona.

The EXCEL Group serves southwestern Arizona. Case management was recently added to EXCEL substance abuse treatment, as well as four In-Home Family Support Specialists. EXCEL partnered with a local faith-based organization, the school and a civic organization to serve children of substance abusing parents in an after school program. EXCEL COOL clients generally receive group-counseling services through one of six satellite sites in the two county area. A 10-bed Level II substance abuse residential facility was established in Yuma in 2002. An 8-bed social detoxification program has operated since 1997. Medically monitored detoxification is provided through out-of-region contracts in Phoenix. Women qualifying for specialty treatment for women and children are sent out of region to providers in Phoenix and Tucson. EXCEL also contracts for opiate medication services through one agency in Yuma. HIV Early Intervention Services are delivered through a contract with Yuma County Public Health. (Note: Effective 7/1/2005, this area of Arizona will be served by Cenpatico Behavioral Health).

Northern Arizona Regional Behavioral Health Authority (NARBHA) serves the five counties of northern Arizona. Overall, NARBHA's region encompasses one half of Arizona, presenting an ongoing service delivery challenge. NARBHA provides basic outpatient and intensive outpatient groups through 9 local agencies, including the Hopi Tribe and White Mountain Apache Tribe. To further extend the reach of treatment services, NARBHA also uses nationally recognized telemedicine, with fourteen sites across the region. NARBHA providers operate 66 Level I detoxification beds across the region, with 12 of these beds "flexed" for higher acuity inpatient substance abuse residential treatment. An additional 19 Level II beds in Prescott provide structured substance abuse residential treatment for all NARBHA members. Women in the NARBHA region receive specialized Level II residential placements through two providers located in Phoenix and Tucson. Employment services are available for the Title XIX population only, while childcare and family support is available only for SAPT priority populations. NARBHA contracts for opiate treatment through agencies located in Flagstaff and Mohave County. One substance abuse supported housing program exists near Show Low. HIV Early Intervention Services are provided through local contracts to county public health in Coconino, Yavapai and Mohave counties.

Pinal Gila Behavioral Health Authority (PGBHA) is responsible for Pinal and Gila Counties in central Arizona. PGBHA clients must travel out of region to receive methadone services and pregnant women's Level II residential treatment. One 10-bed residential program in Casa Grande serves consumers from throughout the region. Employment and family support services are provided locally, but childcare and supported housing is not offered. PGBHA contracts for 10 detoxification beds located in Maricopa and Pima counties. HIV Early Intervention Services are delivered by a behavioral health outpatient agency in Apache Junction. (Note: Effective 7/1/2005, this area of Arizona will be served by Cenpatco Behavioral Health).

ValueOptions (VO) serves the fifth largest city in the U.S. and the surrounding communities in Maricopa County using a combination of community-based outpatient, residential and acute care providers. The geographic size of the County, the diversity of the cultures, and the existence of urban, suburban, and rural regions directly affect the type of service delivery needed and require creativity in meeting the needs of individuals and families. Provider agencies are dispersed throughout the metropolitan and rural areas of the County with the highest concentration in central Phoenix.

ValueOptions operates the single largest behavioral health crisis system in the U.S., comprised of telephone and "warm line" crisis response, crisis mobile teams for adults and children (including specialized Rapid Response Teams for children removed by child protective services and dispatch calls from hospital emergency rooms), alcohol patrol serving the business district of downtown Phoenix, and five Level I subacute facilities (3 psychiatric recovery and 2 detoxification).

ValueOptions providers are either "dual diagnosis capable" with a primary focus of substance abuse that are capable of working with consumers with stable mental health problems or "dual diagnosis enhanced" to treat consumers who have more unstable co-occurring disorders. Overall, VO contracts for 32 medical detoxification beds and 23 substance abuse stabilization beds at two facilities in the Valley of the Sun. The network

includes 250 adult Level II residential treatment beds, including 46 specialty beds for pregnant/parenting women in facilities that accommodate up to 60 infants and children.

Five contracted agencies provide 2,340 methadone slots in Maricopa County. Outpatient family, group and individual counseling is available through 20 substance abuse providers. Five agencies provide employment services for the Title XIX substance abuse population. There are no employment services for non-Title XIX clients. Currently, state-supported childcare maintains a three-month wait list. Value Options has successfully operated a pilot transitional housing program offering a limited number of supported housing beds for COOL clients (20) and six supported housing apartments for women with children leaving residential treatment. VO has prioritized development of linguistically and culturally appropriate providers located in neighborhoods with high-density indigent, Hispanic populations. HIV Early Intervention Services are provided through a single contractor serving all substance abuse and SMI case management sites in Maricopa County.

In addition, a unique informal “network” of four Native American substance abuse agencies deliver residential, outpatient, intensive outpatient and in-home/in-school services for adults and their families using culturally appropriate practices, including sweat lodge, talking circle and traditional healers. One residential facility is a 32-bed specialty program for native women who are pregnant or have young children.

Gila River TRBHA serves the Gila River Indian Community, a reservation of 10,000 plus members located southeast of and bordering the metropolitan Phoenix area. Gila River operates as a staff model case management agency, with contracts for all outpatient, residential and hospital services. Outpatient services are delivered on reservation in home and community settings; more restrictive levels of care, including specialty programs for women with children, are through contracts with providers in Phoenix and Tucson. Gila River also operates a 10-member buprenorphine program through a subcontracted Indian Health Services psychiatrist. HIV Early Intervention Services were developed for the first time during FY 2005.

State Planning

Data Collection – Information Systems. DBHS collects a variety of fiscal, clinical and qualitative data to drive planning and monitor RBHA performance. Routine data collected from the RBHAs include the following: 1) monthly financial reports; 2) eligibility, enrollment and penetration; 3) claims and encounters; and 4) demographic characteristics and outcome measures. Fund types for behavioral health populations are included in these data streams. During SFY 2003, the DBHS initiated a re-design of its data system to consolidate clinical, claims and administrative data and develop the capacity to report National Outcome Measures required by the SAPT Block Grant and the MHSIP project.

Data Collection – Routine Deliverables. In addition to data streams, the DBHS collects a variety of deliverables on a quarterly and annual basis. These include: 1) Access to Care Indicators, assessing RBHA performance in the areas of timeliness of emergency and routine services; 2) the Provider Network Sufficiency Analysis and Development Plan, an annual deliverable focusing on the sufficiency of RBHA contracted networks to provide

all necessary behavioral health services using a logic model based on analysis of multiple data sources. The Plan also includes intended use and network development priorities for the upcoming year for both TXIX and Non-TXIX (SAPT) funding; 3) Quarterly Network Status Report, detailing additions and deletions to the network including prescribers; 4) the Annual Prevention Evaluation, which describes current prevention services using research-based strategies and a risk/resiliency factor framework; 5) the Independent Case Review, a medical record evaluation conducted by an independent contractor using a standardized protocol to assess quality of care; 6) the biennial Consumer Satisfaction Survey.

RBHAs are also required to collect, analyze and monitor planning data, through trending of complaints, grievance/appeals data and provider profiling.

Use of Data in Planning and Resource Allocation. Data collected by DBHS is used to inform decision-making and monitor the regional systems of care in the following areas: 1) contract compliance; 2) financial audits; 3) profile clients and analyze service delivery costs and trends; 4) analyze the quality of care; 5) assess the sufficiency of RBHA-contracted networks to deliver comprehensive treatment services for TXIX/XXI members and SAPT priority populations. In FFY 2001, the DBHS established Network Analysis and Development Teams comprised of the Bureau Chiefs for Clinical Services to assess data specific to network sufficiency and work closely with individual RBHAs on service expansion needs. The Teams were developed to monitor network sufficiency for implementation of 100% FPL for Medicaid coverage and the comprehensive re-design of the DBHS covered services matrix.

During SFY 2003, the DBHS implemented a comprehensive network sufficiency analysis process, known as the Arizona Network Logic Model, which uses data from multiple sources to determine the sufficiency of provider networks. The Logic Model process combines information from the following sources in a process that tests the ability of networks to meet the needs of entitled individuals: problem resolutions/complaints, grievance/appeals, consumer satisfaction surveys, service utilization by covered service category, access to care/appointment standards, financial reports, penetration, and provider network inventory.

Data from Arizona's Treatment Needs Assessment, including the Household Survey, the Tribal Nation Household Survey, the Jail Studies and gaps analysis modeling has been used in conjunction with other special reports to assist in understanding the statewide distribution of need, demand and capacity for substance abuse treatment. These studies generally support the resource allocation formulas used by the DBHS for non-TXIX populations: 1) there is little geographic variation in the prevalence of need for substance abuse treatment in the general population (Household Survey); 2) demand for treatment varies most by population size, with denser areas of the state experiencing the highest demand for treatment (Household Survey, Jail Studies); 3) certain high-risk groups do exist, including young adults, women in the NARBHA region (Household Survey) and Tribal Nations (Tribal Study); 4) statewide, treatment capacity is insufficient to meet need identified in the general population. The service needs for special populations

targeted in the SAPT Block Grant are addressed through monitoring of RBHA wait lists and targeting new funds, as these are available. Concurrent with expansion of Medicaid eligibility during SFY 2001, use of the Arizona Logic Model became a useful planning tools for understanding resource distribution and capacity expansion needs.

Data from the Prevention Needs Assessment includes county and RBHA-specific social indicators of risk and resiliency and the Arizona Student Youth Survey. The social indicators for prevention generally mirror data from the treatment needs assessment and point to high incidence of precursors for behavioral health problems throughout the state. The Student Survey, conducted in collaboration with other state agency partners including the Department of Education, the Arizona Criminal Justice Commission and the Governor's Office, provided detailed county level information on the prevalence of substance use and risk/protective factors in Arizona's public schools. The Office of Prevention conducted multiple community meetings on the Student Survey during SFY 2003, which assisted local jurisdictions in using the information in planning efforts.

State And Regional Planning Councils

State Level Planning. The Behavioral Health Planning Council is a 30-member community body charged with assisting the DBHS in planning and administering the public treatment system. The Council's membership includes representatives of mental health services, substance abuse services, consumers, parents and family members, Native Americans and other minority populations, as well as delegates from the RBHAs and several state agencies. The Council is charged with an advocacy and planning role for the behavioral health system and uses five standing committees to carry out the Council's responsibilities.

Executive Office Level Planning. The State Practice Subcommittee of the Governor's Resource Management System is an 18-member body composed of representatives from State government, State Universities, and one treatment/prevention provider. The Subcommittee was created to review the effectiveness of programs and practices currently used to prevent or treat substance abuse, and to create a framework across all state agencies providing treatment or prevention services to collect and report outcome measures. In the spring 2005, this informal subcommittee replaced the Governor's Drug and Gang Policy Council, which sunset under Arizona law. During 2005, BSAPT also became an active participant in the Governor's Strategic Prevention Framework Epidemiology Group, established in January 2005.

Regional Planning. As a requirement of the ADHS contract, RBHAs maintained a Community Advisory Board of at least 15 members of which at least three must be family members and two consumers. The Community Boards are required to be reflective of the geographic and ethnic diversity of the region. Boards provide input on allocation and expenditure of behavioral health service funds.

Planning Initiatives

DBHS Strategic Plan. In the spring 2001, DBHS management staff developed a new mission and vision for behavioral health services during a two-day planning session. The

plan encompassed more than 15 strategic initiatives for the DBHS, including the child welfare/substance abuse partnership (Joint Fund), the development of specialized substance abuse services for children, and implementation of the expanded covered services matrix for Medicaid-compensable treatment services. The Plan was updated in SFY 2002 and 2003 to focus more closely on strategic initiatives necessary to streamline the assessment process and reduce clinical paperwork in the enrollment process, as well as to launch a renewed vision for behavioral health care in the state. The 2003 Plan included three key initiatives that are currently in place: 1) development of a single, standardized behavioral health assessment for all populations; 2) consolidated standards for credentialing and privileging clinicians to conduct the assessment; and 3) revision of service authorization criteria. Under these initiatives, the Arizona behavioral health system is aligning its focus to improve engagement of persons into treatment, involve families and consumers in the development and delivery of care, develop a clinical team model to drive service planning in lieu of authorization criteria and reduce clinical paperwork.

In 2004, the DBHS Strategic Plan was aligned with the President's New Freedom Commission Goals and Objectives. Key BSAPT initiatives in the 2004-2006 plan include: 1) develop and launch a campaign on stigma within the behavioral health system; 2) develop methods to involve consumers and family members in oversight and evaluation of the system; 3) implement National Outcome Measures; 4) establish an Evidence Based Practices Committee to improve the quality of substance abuse treatment; 4) expand capacity for detoxification and substance abuse peer support services; 5) implement a suicide prevention program. Activities under these goals are currently underway.

Monitoring to Ensure Link to Need

DBHS utilizes a variety of routine and special data to establish contract standards for RBHA performance. These standards are subject to sanction and encompass such areas as network sufficiency, submission of assessment data, financial ratios, and timeliness standards among others. DBHS maintains a comprehensive year-long monitoring process including annual site visits (Administrative Reviews), reports and deliverables and special Network Analysis and Development Teams to ensure that funded programs serve communities and populations with the highest prevalence and need. As of 2005, the Evidence Based Practice Committee was established to develop a State-level strategy on implementing best practices that align with goals of recovery, family involvement, and improving outcomes.

FY 2005 (PROGRESS):

The following table presents in summary fashion, by Region, facilities provided during the target year for populations relevant to the SAPT Block Grant.

Provider Type/Service	Minimum Number					
	GSA 1	GSA 6	GSA 3 ⁵¹	GSA 5	GSA 2	GSA 4
Level II Specialty Program for women with children	0 (acquired out of Region)	113 adult beds 73 child beds	4 adult beds ⁵² 4 child beds	27 adult beds 32 child beds	0 (by single case agreement acquired out of Region)	4 adult beds 8 child beds
Level III Specialty Program for women with children	0 (acquired out of Region)	0	0	0	0	0
Outpatient Specialty Program for women with children	2	*	1 agency	3 agencies	1	0
Habilitation Provider or Community Service Agency (CSA) specialized for women with children	0	0	0		0	0
Peer Support	0	25	9 peers	24 peers	10	20
Family Support	0	*	4 family members (projected) ⁵³	16 family members (projected)	10	6
Supported Housing for Women with children	(only wrap services throughout the Region)	6 apartments	SAPT funds are not used to provide housing; however wrap-around services (includes case management, housing support and flex funding, peer support, etc.) are provided to members receiving treatment through SAPT funds		0	0
HIV Early Intervention Services	(3 county providers)	1 outpatient agencies 1 drop-in centers	1 outpatient agency ⁵⁴	1 outpatient agency; 1 drop-in center ⁵⁵	1	4 outpatient agencies

Footnote:

* The data was not previously collected in this way. Data collection methodologies will be modified for future reporting.

NOTE: Specialty programs for women with children are defined as sites that deliver the following: (1) treat the family as a unit; (2) provide gender-specific substance abuse treatment, therapeutic interventions for children, child care, case management, transportation; (3) provide or refer for primary medical care, primary pediatric care.

The following new services were established to meet the needs of substance abuse clients eligible under Medicaid and/or the SAPT Block Grant through the Network Development process (see Goal 13 for greater detail):

Community Partnership of Southern Arizona (CPSA)

- La Canada, a residential substance abuse program for adolescents formerly available to only court-involved youth, became accessible to children within the CPSA system. La Canada offers an intensive 30-day residential array of family-based services.
- Adopted and implemented in Graham, Greenlee, Cochise and Santa Cruz Counties the '7 Challenges Program', delivered concurrently with a youth Anger Management Substance Abuse Group; this program is designed to motivate a commitment to change.
- Participated in Drug Court in the communities of Sierra Vista, Benson, Willcox and Douglas.
- Launched the Recovery Support Specialist Institute, a focused 8-day training program for consumers who are then hired by provider networks to deliver peer support services.
- Deployed American Society of Addiction Medicine (ASAM) training on adolescents with substance use disorders.
- Developed a comprehensive training conference on methamphetamine abuse that will inform participants on the scope of the problem and best practice prevention and treatment approaches.
- Launched a Workforce Development Initiative (four training cycles in 2005) that included a training and certification program for peers seeking to assist other consumers. Over 40 individuals participated.
- Launched "The Shelter Plus Care 3" program to provide nine tenant-based Housing First units as well as wraparound services for homeless individuals. This housing-grant funded program includes persons with a Substance Use Disorder who may be currently still involved with substances. Housing First allows the participants to receive rental assistance prior to abstinence or participation in a behavioral health program. This project was realized through collaboration between the City of Tucson, Comin' Home (a veteran's program), and TMM Family Services (faith-based organization).
- Participating in the development of "damp housing".
- Enhanced opioid maintenance services for residents of Cochise, Graham, Greenlee, and Santa Cruz Counties by adding buprenorphine to the formulary, developing a buprenorphine protocol, and ensuring three physicians (including the network Medical Director) were authorized to provide buprenorphine.
- Enhanced opioid maintenance services for residents of Pima County by adding an additional outpatient opioid treatment site newly developed and operated by an existing service provider (COPE).

- Developed a new 12-bed, Level II substance abuse stabilization/detoxification facility (Southeastern Arizona Substance Abuse Continuum, or SEASAC) serving individuals with co-occurring as well as substance abuse disorders, in Benson.

EXCEL Group

- Provided co-occurring disorder training to 7 staff in order to improve services offered at Level II residential facility.

Northern Arizona Behavioral Health Authority (NARBHA)

- Acquired funding and developed plans for an eight bed supported housing facility in Holbrook for substance abusers, and clients with a serious mental illness; expected completion of the project is January 2006.
- Continues to recruit recovery specialists via NAZCARE and at sub-area agency provider sites to extend peer-delivered support services.
- Contracted for 16 sub-acute beds in Cottonwood with approximately half available for substance abuse treatment.
- Initiated a review of capacity for medical and Level 2 detoxification services in Flagstaff.
- Provided gender-specific outpatient groups for pregnant/parenting women in Kingman and Show Low.

Pinal Gila Behavioral Health Authority (PGBHA)

- Added contract for additional opioid treatment with existing private provider.
- Planning with Southwest Behavioral Health Services/Rim Guidance Center to open a Level 1 psychiatric/substance stabilization facility in Payson this coming year.
- Expanded adolescent substance abuse program capacity by implementing the “Seven Challenges” model for intensive outpatient programs in Payson, Coolidge, and Eloy/Arizona City.
- Partnered with Pinal Hispanic Council to recruit and retain peer paraprofessionals to provide peer support and vocational services to clients with substance abuse and co-occurring disorders.

ValueOptions (VO)

Narrative of Progress documented during the target year.

- Contractually require all agencies receiving a combination of general mental health and substance abuse funding to modify their programs to “dual diagnosed capable” or “dual diagnosed enhanced” models of care.
- Prioritized \$1 M in SAPT funding for services to non-TXIX parents referred through Child Protective Services.
- Launched an initiative to “co-locate” substance abuse provider staff at outpatient clinic and case management sites serving persons with mental illness. As of July 2005, 15 of 22 clinic sites had co-located substance abuse staff.

- Funded providers to implement substance abuse peer and family support services by hiring recovery specialists at 10 agencies serving Maricopa County.
- Fostered expanded recovery housing opportunities by collaborating with five substance abuse providers to offer supported housing to women and children in transition from residential treatment.
- Opened a Level 2 residential treatment program through Community Bridges to provide intensive treatment, supportive and medical care to 24 homeless pregnant women with up to 32 children, including those with a co-occurring disorder.
- Expanded opioid treatment services in both North and West Phoenix by establishing two new sites capable of serving 425 new clients.

Gila River Indian Community

- Hired a doctor part time (specialties in addictions, geriatrics, and internal medicine, and has a Drug Addiction Treatment Act of 2000 waiver) to serve individuals in need of opioid abuse treatment by providing Subutex and/or Suboxone.
- Providing case management services for addicted clients living with AIDS.
- Purchasing off-reservation specialized residential services in Phoenix for pregnant and/or parenting substance abusing women.
- Arranging for the purchase of testing services on-reservation to augment HIV/AIDS Early Intervention Services.

FY 2006 (INTENDED USE):

Statewide Goals. The BSATP will strategically focus on enhancement and expansion of substance abuse treatment and recovery support services in the following areas:

- **Peer Support/Recovery Support Specialists**, with a goal of doubling the number of substance abuse peer workers employed in the behavioral health system during 2006.
- **Supported Housing**, with a goal of expanding availability of supported housing with wrap-around treatment supports statewide.
- **Methamphetamine Centers for Excellence**, with a goal of establishing centers in three regions (ValueOptions, CPSA, Gila River Indian Community), developing new services in two regions (Cenpatico of Arizona) and continued support of tribal nations through training, assistance and funding as available.
- **Latino Family Involvement Center**, with a goal of establishing a new provider focused on community mobilization and direct support service delivery for Hispanic and minority families impacted by substance abuse.
- **Adolescent Substance Abuse Services**, with a goal of maximizing the CSAT Adolescent Treatment Coordination grant to expand availability of substance abuse education, early intervention and treatment services within the context of family and culture.

Cenpatico Behavioral Health of Arizona

(New contractor for Yuma/La Paz Counties (GSA 2), replacing EXCEL Group as of 7/1/05)

- Increase number of behavioral health recipients to deliver Peer Support Services.

- To improve quality and availability of treatment utilizing evidence based treatment approaches for persons experiencing methamphetamine abuse disorders.
 - Develop contracts for Therapeutic Foster Care settings specializing in supports for adults/kids who have completed treatment for methamphetamine abuse.
 - Participate in ADHS/DBHS training on evidence based treatment models and fidelity assessment for clinical supervisors.
 - Provide training to providers in methamphetamine best practice treatment through a locally organized conference or training event.

Cenpatico Behavioral Health of Arizona

(New contractor for Pinal/Gila Counties (GSA 4), replacing PGBHA as of 7/1/05)

- Increase number of behavioral health recipients to deliver Peer Support Services.
- To improve quality and availability of treatment utilizing evidence based treatment approaches for persons experiencing methamphetamine abuse disorders.
 - Identify and contract with a consultant with expertise in Native American cultural treatment to develop programming for the San Carlos Tribe.
 - Develop contracts for Therapeutic Foster Care settings specializing in supports for adults/kids who have completed treatment for methamphetamine abuse.
 - Participate in ADHS/DBHS training on evidence based treatment models and fidelity assessment for clinical supervisors.
 - Provide training to providers in methamphetamine best practice treatment through a locally organized conference or training event.

Northern Arizona Regional Behavioral Health Authority (NARBHA)

- Provide increased capacity for Sign Language or Oral Interpreter Services to members with specialized language needs.
- Maintain current prescriber levels; enhance prescriber capacity for Hopi Tribal services; project capacity needs based on population changes, new initiatives and utilization; assist providers with recruitment of psychiatric practitioners.
- Expand availability of specialty therapy groups for substance abusing women with children in each sub-region of Northern Arizona.
- Establish and/or expand social and medical detoxification including triage in Flagstaff to include crisis intervention, detoxification services, residential services, and a full range of substance abuse and chemical dependence outpatient services.
- Expand self-help/peer support provided by family members and consumers.

Community Partnership for Southern Arizona (CPSA)

- Develop an action plan for GSA 5 and 3 to implement culturally proficient practices and promote partnering with culturally rich agencies, to include outreach to minority populations including coordination with Native American tribes.
- Expand self-help/peer support provided by family members and consumers, and continue training institutes for Peer and Family Support Specialists.

ValueOptions (VO)

- Increase family involvement and family support by surveying providers, analyzing survey responses and preparing a plan to facilitate family involvement program.
- Complete needs assessment for culturally proficient services for the Asian and Native American population.
- Monitor implementation of additional prescriber capacity, establish community standard for prescriber time, implement identified community standard/model, and re-analyze sufficiency of prescriber capacity.
- Develop substance abuse education/health promotion services for consumers and family members at all residential substance abuse provider agencies and IOP programs.
- Analyze existing and new data to determine need to extend detoxification capacity to the western portion of Maricopa County.
- Increase the number of co-located substance abuse treatment staff to all ValueOptions clinic sites for SMI adults.
- Continue to analyze wait list data to determine sufficiency of residential beds for pregnant and/or woman with dependent children.
- Continue and expand supported housing for women and children.
- Double the number of consumers providing peer support services in substance abuse treatment programs.

Gila River Indian Community

- Continue provision of a part time doctor to serve individuals in need of opioid abuse treatment by providing Subutex and/or Suboxone.
- Continue providing case management services for addicted clients living with AIDS.
- Continue purchase of off-reservation specialized residential services in Phoenix for pregnant and/or parenting substance abusing women.
- Continue the purchase of testing services on-reservation to support HIV/AIDS early intervention services.

GOAL # 2.-- An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies (See 42 U.S.C. 300x-22(b)(1) and 45 C.F.R. 96.124(b)(1)).

The Arizona Department of Health services (ADHS) operates an Office of Prevention composed of three full time staff persons, Lisa Shumaker who is the Manager for the Bureau for Substance Abuse Treatment and Prevention, Heather Brown and Merv Lynch who are both Behavioral Health Program Representatives. ADHS contracts with T/RBHAs and Tribal Contractors to administer prevention services in the state. ADHS works in partnership with T/RBHA Prevention Coordinators and Tribal Contractors to set statewide direction for the application and advancement of primary prevention programs and practices through consultation, technical assistance, and training. Regional Behavioral Health Authorities (RBHAs) provide prevention services including all CSAP strategies through a network of specialized, community-based subcontracted agencies.

Services are provided for people who reside in their geographic service area. Arizona is divided into six geographic service areas (GSAs). GSA 1 consists of Coconino, Navajo, Apache, Yavapai, and Mohave Counties. GSA 2 includes La Paz and Yuma Counties. GSA 3 is composed of Graham, Greenlee, Cochise, and Santa Cruz Counties. GSA 4 is comprised of Pinal and Gila Counties. GSA 5 is Pima County and GSA 6 is Maricopa County.

T/RBHAs are responsible for the operation and coordination of the prevention service delivery network, including contracting and payment for prevention services, monitoring, and improving the effectiveness of services.

DBHS has Intergovernmental Agreements (IGAs) with four Arizona Tribes to provide prevention services for Native Americans on the Navajo Nation, Colorado River Indian Tribes, Gila River Indian Community, and Pascua Yaqui Tribe. Other tribes receive prevention services from the local RBHA. Native Americans who live in non-reservation communities access prevention services through the RBHA system in the same manner as other Arizona residents.

Prevention programs funded through ADHS/DBHS decrease the prevalence and severity of behavioral health problems among populations that do not have a diagnosable behavioral health disorder. Prevention is accomplished by developing the strengths of individuals, families, and communities. Prevention in the DBHS system uses evidence based strategies and research on protective and risk factors as a basis for prevention efforts.

FY 2003 (Compliance):

OBJECTIVE: Maintain budget and allocation controls to conform to the "20% rule".

ACTIVITIES:

- Ensure the ADHS Budget Office performs monitoring on Block Grant requirements using existing reports and controls.
- Ensure the DBHS Office of Business Operations conforms to requirements in preparing contract allocation logs.
- Continue the Bureau of Substance Abuse Treatment and Prevention oversight of the distribution of funds in contract so that requirements are met.

COMPLIANCE:

- **Contracts/Policy:**

The SAPT Block Grant accounts for approximately 50% of prevention funding administered by ADHS/DBHS. All processes outlined under Activities were used to insure the 20% rule was followed for FY 2003. The role of the ADHS Budget Office included review of financial forms contained in the 2003 Block Grant application and computation of the annual State Prevention Set Aside including identifying appropriate accounts for state funded prevention services. The BSATP reviewed the prevention allocation during the annual development of funds allocation schedules by the DBHS Office of Business Operations to ensure appropriate isolation of prevention set-aside funds. (Please refer to Form 6A, Col. B, Prevention Strategy Report, for a full listing of activities by CSAP code that SAPTBG funding supports in Arizona. These activities continued to be supported with the 2003 award.) In addition, funds were used to increase the skills of the prevention workforce, enhance monitoring and evaluation abilities at the RBHAs, and improve program evaluation at provider agencies.

- **Oversight:**

SAPT Block Grant funds supported prevention efforts coordinated by five RBHAs (Value Options, Community Partnership of Southern Arizona, Northern Arizona Regional Behavioral Health Authority, Pinal Gila Behavioral Health Authority, and the EXCEL Group) and one Tribal Regional Behavioral Health Authority (Gila River Regional Behavioral Health Authority) during state fiscal year 2003. In total, 163,903 people participated in prevention programs during 2003 that were funded in whole or in part by the SAPT Block Grant.

RBHA prevention programs were required to follow a logic model; use research-based elements and core measures (standardized instruments) in their program design and target risk and protective factors related to behavioral health conditions.

ADHS monitored the implementation of the RBHA prevention activities through an annual administrative review, monthly meetings with Prevention Coordinators, and review of an annual evaluation report. RBHAs monitor the implementation of prevention programs through site visits to providers, regularly scheduled meetings with providers, review of quarterly reports and annual outcome evaluation reports.

The following specific activities were undertaken during FY 2003:

- **Information Dissemination:**

Approximately 5% of prevention funds were applied to information dissemination strategies serving 12,000 people.

A variety of information dissemination activities took place across the state and throughout 2003. Specific examples are provided below:

The Southeastern Arizona Behavioral Health Services resource library in southeastern Arizona distributed 22,393 pieces of information on substance abuse and provided materials for 26 media campaigns. Materials were distributed in English and Spanish. Target population: Community at large, parents

In Tucson, written information about substance abuse was provided to 274 people through three social service fairs and a senior citizen health fair. Target population: Older adults and persons who care for older adults

Each of the five Regional Behavioral Health Authorities operated RADAR sites for distribution of local prevention materials. The RADAR site in Yuma strategically placed satellite sites in primary care physician offices, day care centers, schools, and counseling offices. Over 10,000 informational brochures, written material and pamphlets were distributed. Thirty percent of materials were in Spanish. Target population: Community at large

Several providers and Division staff wrote articles on substance abuse, violence and/or risk and protective factors for newsletters and newspapers in rural communities. Target population: Community at large

In Yuma alone, messages from the EXCEL Group about the harmful impact of alcohol use and violence reached over 6,000 youth and school staff. Target population: Youth and school staff in Yuma.

- **Education:**

Approximately 66% of prevention funds were applied to education strategies serving over 108,000 parents, community members, mentored youth, classroom youth, after school program youth, and school staff. Activities included education on the development of life skills, parenting skills, leadership skills, and the development of relationships.

The Area Agency on Aging in Maricopa County served over 4,000 older adults in an outreach program designed to teach them life skills development strategies. Program

outcomes demonstrated an improvement in life satisfaction. Target population: Older adults and their caregivers.

The Child and Family Resources family support and educational program in Tucson showed positive changes in parenting skills, employment, and educational achievement of adolescent parents. Target population: Adolescent parents.

CODAC's Kino Neighborhood project inspired positive improvements in parenting skills among more than 300 parents. Target population: Parents with few resources.

Community Behavioral Health Services' Reconnecting Youth project in Page inspired improved academic skills and achievement among the 76 participants. Target population: Youth at risk for school failure as evidenced by frequent disciplinary referrals.

Ebony House's Strengthening Families project in Phoenix targeted approximately 200 African American parents. The program was able to show positive outcomes including reduced disciplinary problems, better problem management, and improved self-esteem. Target population: African American and Hispanic parents.

EMPACT's life skills development project in Gila Bend demonstrated positive improvements in social skills among participants. Target population: Elementary School youth in Gila Bend.

In Sacaton, the Gila River Health Care Corporation began to implement the Incredible Years prevention program with kindergarten and preschool children throughout the Gila River Indian Community. The same organization also commenced implementation of Botvin's Life Skills Training with upper elementary and lower junior high school grades. As the program began near the end of the school year, evaluation outcomes were not yet available. Target population: Akimel O'Odham youth in grades K-8.

The Pinal Respect Project, implemented by Horizon Human Services in the town of Stanfield, was able to demonstrate reductions in violence among students. This project was developed in response to high levels of violence in the community and school. Target population: Low-income Hispanic youth enrolled in Stanfield School.

The Parents Anonymous program in Apache and Coconino Counties showed improvements in family management skills and communication among the 300+ adults who benefited. The Parents Anonymous program in Maricopa County demonstrated positive changes in knowledge of child development and appropriate expectations. Target population: Parents.

Phoenix Indian Center's family support program in Maricopa County showed positive improvements in academic performance among participants. Target population: Urban Native American families.

Pima Prevention Partnership's Family Strengthening program reached over 600 people and improved communication skills and family bonding among participants. Target population: Pima County Parents.

Prehab's prevention program reached over 1,000 youth in Maricopa County. The project showed positive improvements in academic skills. Target population: Youth in Maricopa County.

The Scottsdale Prevention Institute's family support program demonstrated increased parent child activities. Target population: Spanish-speaking families in Scottsdale.

The Guidance Center's Project Resiliency in Flagstaff showed participants had more academic success than a comparison group. Target population: Elementary school youth in Page.

- **Alternatives:**

Approximately 14% of prevention funds were applied to alternative strategies. Over 20,000 youth statewide participated in alternatives programming.

SAPT Block Grant funds supported activities designed to provide alternatives to substance abuse. These activities included after school programs, prosocial recreation, and adventure-based programs among others. Alternatives were offered as a component of a more comprehensive prevention program.

The Southern Arizona AIDS Foundation helped 47 youth educators in Tucson complete a 24-hour training in health promoting messages. These peer leaders then delivered more than 2,800 health-promoting messages to peer and family members. Topics ranged from substance abuse and STDs/HIV/AIDS to the culture of violence. Target population: Youth and families in Tucson.

The Big Brothers Big Sisters Mentoring Programs in Maricopa and Navajo Counties reached approximately 800. Program outcomes demonstrated increased self-confidence and aspirations. Target population: Youth.

The Casa de Esperanza mentoring program in Southern Pima County reached over 2,000 children. Program outcomes reflected an increase in school attachment. Target population: Youth in Southern Pima County.

Youth involved in a leadership group organized by La Frontera Center in Tucson drafted a play about substance abuse, which they then presented throughout their community. Target population: Youth in Tucson.

- **Problem Identification and Referral:**

It is estimated that prevention professionals referred 2,000 people statewide to treatment services. Regional Behavioral Health Authorities offered training to prevention provider agency staff members on identification of behavioral health problems, making appropriate referrals to services.

1,164 people were screened for depression on National Depression Screening Day. As a result, 284 referrals were made to counseling. Target population: Community at large.

- **Community-Based Process:**

Approximately 8% of prevention funds were applied to community-based processes. Over 11,000 community members participated in community-based efforts. Target populations for community-based process are: Community at large.

Across the state, mobilization efforts increased with successful partnerships formed between prevention providers and fraternities, private for profit corporations, schools, Boys and Girls Clubs, statewide advocacy coalitions (Arizonans for Prevention), faith-based agencies, and Universities.

Specific services and activities include formation of coalitions of people to address issues related to the prevention of substance abuse. For example, in Gila County (central Arizona), Horizon Human Services noted that although substance abuse is the number one social problem in the county, there was no coalition of stakeholders formed to address substance abuse. The provider brought together local school staff, police, clergy, youth, social service providers, politicians, and parents to establish a community anti-drug coalition. The coalition conducted a comprehensive needs assessment, composed of a review of local statistics and interviews with key informants, and discussed their interpretation of the results. Based on their interpretation, they developed and implemented a parent support and education program in a remote part of the County that had few resources and high need.

In Southern Arizona, Community Partnership of Southern Arizona required all providers to include community mobilization as a part of their program in an effort to increase focus on substance abuse.

- **Environmental:**

Over 11,000 people (youth, parents, community members, stakeholders) statewide contributed to the advancement of environmental strategies using approximately 7% of funds.

CODAC Behavioral Health Services, in collaboration with members of the Arizona Human Services Council, created a position paper that conveyed the Council's position

on substance abuse and prevention. The paper was distributed to state legislators, government, and providers.

SAPT Block Grant funds support community activities to address school and community policies, norms and conditions around ATOD usage, guidance and the monitoring of availability of ATOD. For example:

- Information and Referral Services organized a coalition of youth that drafted anti-bullying legislation to be brought before the state legislature in the winter of 2004. This program serves a target population of middle school aged youth in Pima County.
- During the fiscal year, community members and coalition members proposed several changes to the current liquor license process including elimination of subsidies, analysis of the food/alcohol split, and funds for people to testify before the liquor board. This program serves a target population of Southern Tucson.
- A Pima Youth Partnership coalition on the Tohono O'Odham Nation created a curfew for youth. The target population for this effort is residents of the Tohono O'Odham Nation.

- **Evaluation:**

Evaluation was a common agenda item for many RBHAs/provider meetings. Providers requested and received technical assistance with development of valid and reliable evaluation tools and incorporation of core prevention evaluations into their programs. Regional Behavioral Health Authorities continued to encourage providers to use the Arizona Logic Model in program planning and evaluation. Providers continued to receive assistance with writing goals and objectives. This emphasis and training on evaluation resulted in better end of the year evaluation reports that included statistical analysis of program outcomes. Regional Behavioral Health Authorities explored the application of cost benefit analysis to their programs. Workshops on evaluation were offered during the Annual Statewide Prevention Provider Meeting.

GOAL: To increase the skills and capacity of the prevention workforce.

OBJECTIVE: The RBHAs will continue to ensure that staff members of programs receiving prevention funds from the SAPT Block Grant have completed core prevention training.

ACTIVITIES:

Provide monitoring and technical assistance to the RBHAs to ensure that core prevention training is provided to the workforce. (Strategy: Education)

COMPLIANCE:

Monthly meetings were held with RBHAs in which they each gave an update on their program and had an opportunity to express needs for technical assistance. RBHAs also met with providers in their network regularly. Frequency varied from monthly to

quarterly. Staff members of the Office of Prevention attended local RBHA meetings with providers at least once annually and conducted an annual Administrative Review of the RBHAs.

The Office continued to spearhead collaboration with the Arizona Prevention Resource Center (APRC) and RBHA Prevention Coordinators to ensure Basic Prevention Skills training was available at least once annually to providers. Providers from each region received training and technical assistance from APRC to learn how to implement the basic skills training within their agencies. Prevention subcontractors became more involved in the perpetuation of core prevention training. The Arizona Prevention Resource Center co-facilitated workshops throughout the state with local providers, with the ultimate goal being that providers would be able to take over facilitation themselves. All professionals who deliver prevention services were required to complete basic prevention competency training. Due to staff turnover, 84% of the prevention workforce completed this training in 2003.

The annual Prevention Evaluation Report included a monitor for RBHA reporting of how many prevention staff completed the core prevention training. All RBHAs continued to place emphasis on ensuring prevention programs have staff that are appropriately trained. The majority of the statewide prevention workforce successfully completed formal core prevention skills training and Advanced Risk and Protective Factor training. Due to turnover among staff, it was necessary to make these trainings available locally on an ongoing basis to ensure new staff received appropriate exposure.

In collaboration with the Arizona Criminal Justice Commission, the Governor's Office, and the Arizona Prevention Resource Center, the Office of Prevention provided trainings for prevention subcontractors, education professionals, and community activists on the results of the most recent Arizona Youth Survey. The Survey, supported in part by the CSAP Prevention Needs Assessment, used the risk and protective factor framework in its biennial assessment of substance use by public school students. Results of the needs assessment as well as educational materials were made available to the public via the ADHS web site.

Training on use of research based strategies in life skills and parenting programs was provided to approximately 180 prevention professionals during the Statewide Prevention Provider Meeting held in June 2003. The meeting included specific training for using need assessment results, adapting programs to Arizona populations, evaluation, community development, and cost benefit analysis.

The Office of Prevention hosted a series of internal DBHS meetings throughout the winter and spring 2003 to expose RBHA Monitoring Teams to region-specific data from the prevention needs assessment. The Teams used this information to understand the nature and extent of risk and protective factors within each RBHA catchment area and how to identify populations and communities with greater needs for behavioral health treatment and support services.

RBHAs offered ongoing training and technical support for providers through regularly scheduled group meetings and an annual site visit. For example, ValueOptions established a Training Advisory Committee, which took responsibility for ensuring basic prevention training was available to all providers in the ValueOptions network. ValueOptions provided training for providers in grant writing, logic models, and specialty populations such as the elderly, Native Americans, women, and evaluation and cultural competence.

GOAL: To enhance the monitoring capabilities of the Regional Behavioral Health Authorities.

OBJECTIVE: By October 1, 2003 each RBHA will have a monitoring tool in use while conducting site visits that includes measures of qualitative items related to fidelity and implementation of research based program elements.

ACTIVITIES:

- Provide technical assistance to RBHAs regarding state of the art models for evaluating the effectiveness of programs. (Strategy: Education)
- Assist in the implementation of a tool that will provide quality feedback to RBHAs regarding progress of provider agencies and the quality of programs. (Strategy: Education)

COMPLIANCE:

Each RBHA used a standard monitoring tool to assess progress of provider agencies and provide constructive feedback during spring 2003 site visits. Some Regional Behavioral Health Authorities conducted more frequent site visits, which included application of their monitoring tool and constructive feedback that was used to make mid-year improvements in programming.

RBHAs provided substantial training to providers in the implementation of best practice programs and application of research based methods on an ongoing basis. The RBHA Annual Prevention Evaluation Reports are now far more descriptive in the area of needs assessment, evaluation design and fidelity measuring, indicating a more thorough monitoring of providers.

GOAL: To enhance the evaluation capabilities of programs contracted with the Regional Behavioral Health Authorities.

OBJECTIVE: By October 1, 2003 eighty percent of community programs will have a core measure pre/post evaluation.

ACTIVITIES:

- Provide technical assistance and leadership to the RBHAs in prevention evaluation. (Strategy: Education)

- Assist in the implementation of core measures and related instrumentation for evaluating the effectiveness of programs.
- Monitor the RBHAs on achieving the 80% target.

COMPLIANCE:

- **Technical Assistance in Evaluation**

Technical assistance was provided to Regional Behavioral Health Authorities via monthly Prevention Coordinator Meetings in advancing the use of the core instruments.

- **Core Measures**

The Office of Prevention encouraged all RBHAs to incorporate core measures into their evaluation. Two RBHA Coordinators developed an hour-long workshop on the use of core measures in evaluation and provided that workshop at the 2003 Annual Provider Meeting.

- **Monitor use of Core Measures**

More providers used core measures to evaluate their programs than in previous years. The majority of providers integrated core measures into their pre and post evaluations. The RBHAs worked with providers one-on-one, in groups, and used consultants to help providers improve the quality of their program evaluations. They held programs accountable for outcomes and reserved funding for programs showing success and positive outcomes.

GOAL: To improve the quality of program focus and methodology within the prevention provider network.

OBJECTIVE: By October 1, 2003 the RBHAs will demonstrate use of the Arizona Needs Assessment data in their planning of program strategies, activities and evaluation methodology.

ACTIVITIES:

- Disseminate needs assessment data to RBHAs and provider agencies.
- Provide training and/or technical assistance in matching research-based strategies to identified need.

COMPLIANCE:

- **Needs assessment dissemination**

Copies of the results of the Arizona Youth Survey were distributed to RBHAs and providers at the June 2003 Statewide Prevention Provider Meeting.

- **Training in matching strategy to need**

The Office of Prevention used data from the 2002 Arizona Statewide Needs Assessment to help RBHAs and providers prioritize communities and populations for service and to design interventions based on risk factors for behavioral health related problems. The Department placed emphasis on strengthening program methodology and evaluation processes and RBHAs facilitated training on these topics for providers. A special workshop on how to interpret the results and use data to develop prevention programming highlighted the survey findings. The Office of Prevention also conducted a number of internal trainings on using CSAP Needs Assessment data to better understand populations and areas within the state with high needs for clinical interventions and treatment. Training on the application of the Arizona Youth survey was provided to school prevention staff throughout the state during the spring of 2003. Statewide needs assessment data and Arizona Youth Survey results were posted on the Department web site along with education materials regarding the application of the data.

In addition to statewide needs assessments, the RBHAs expressed their priorities regarding target groups, methods, and issues to providers via the request for proposal and contracting process. For most RBHAs, this included a requirement that subcontractors either conduct a localized needs assessment or align their programming with a region-wide assessment conducted by the RBHA. Needs assessments included a review of local statistical data, interviews with key stakeholders, community forums and other methods. Both RBHAs and providers applied results from the Arizona Youth Survey in addition to local needs assessments to focus substance abuse prevention activities. Programs targeted communities with exceptionally high rates of prevalence, identified communities with high levels of AHCCCS eligibility, identified the need to develop programming for children with low literacy, focused programming on vulnerable age groups, identified the need for outreach to parents and elders, and adapted programs to better meet the needs of Native American and Hispanic communities.

In collaboration with the Department of Economic Security, CSAP and SAMHSA, the Division hosted a forum entitled "Creating Collaborations: Preventing Alcohol and Prescription Drug Use Problems in Older Adults." The daylong forum was inclusive of providers, RBHAs, and Division staff from throughout the state. In addition to training in risk and protective factors for older adults, the forum included opportunities for discussing local gaps in service and collaboration.

GOAL: Prevention Targeting.

OBJECTIVE: To establish criteria, training and reporting methods for prevention under the new behavioral health covered services.

ACTIVITIES:

- Review and refine requirements and guidance contained in the RBHA contract, the annual Prevention Report and the Prevention Framework.
- Develop a work plan to improve targeting of primary prevention to selected and indicated levels.
- Develop training and support recruitment and development of prevention agencies as community service agencies.

COMPLIANCE:

- **Annual Prevention Report and Prevention Framework**

The Division mobilized a group of stakeholders to commence revision of the Prevention Framework. Participants in the revision process included representatives from the Governor's Office, Tobacco Education and Prevention Program, provider agencies, regional behavioral health authorities, Behavioral Health and Aging Coalition, Arizona Prevention Resource Center, Arizona State University, Office of Women and Children's Health, Department of Economic Security, and Arizona Criminal Justice Commission. The group met approximately 3 times in 2003 to discuss the scope of the Framework and process by which it would be revised. The group agreed that the Framework should not be a Framework for the entire Arizona prevention system, but rather a document reflecting the Division of Behavioral Health's strategic plan for prevention for the next five years. The annual prevention report was reviewed and no changes were made.

- **Matching Programs to Assessed Needs**

The Division undertook an assessment of need for substance abuse prevention services in Arizona. The Division used a variety of data sources to assess need including: prevalence of behavioral diagnoses of treatment recipients, vital statistics, social indicators of substance abuse and major alcohol/drug related consequences, existing prevention resources, key informant opinion, and Arizona Youth Survey Data. Based on this review, the Office developed a work plan in the summer 2003 to initiate a process for improved targeting of prevention resources in these areas, including promotion of specific strategies for selected and indicated interventions with these populations and communities.

Substance abuse was the most prevalent diagnosis among persons enrolled for treatment in the Arizona Behavioral Health System. Use of alcohol was the most common substance abused. Marijuana also had a high rate of reported use. The rate of

methamphetamine use was also rising. Several gaps in the prevention system were identified. First, three tribes in Arizona (Hopi, Navajo, and San Carlos Apache) approached the Division requesting help with a quickly growing methamphetamine problem. Hopi and San Carlos were not receiving prevention services at all and the Navajo Nation was receiving state prevention funds, but was not using them for prevention. The Arizona Youth Survey showed an alarmingly high rate of youth were using drugs. The border areas of the state reported increasingly negative impact of the illegal drug trade. It was also determined that the evaluation system was not providing enough useful information. The Division began communications with the three tribes to discuss their prevention needs, began participation in Border CAPT activities, and began looking at ways to improve the evaluation system.

Arizona had the sixth highest suicide rate in the nation. . The majority of suicides involved the use of drugs or alcohol. Rates were exceptionally high in areas characterized by chronic alcohol abuse and rising problems with methamphetamine. Geographic isolation and a lack of evidence-based programs targeting these groups were barriers to providing appropriate prevention services. Mood disorders, which correlated with increased substance abuse and suicide, were the second most common diagnostic category of people served in the Behavioral Health system. Counties with high rates of substance use, completed suicide , and low presence of prevention programming were brought to the attention of Regional Behavioral Health Authorities. Increases in block grant funds were used by Regional Behavioral Health Authorities to add suicide prevention sessions to select substance abuse prevention programs when appropriate. New programs arising from this funding include the following:

- The Youth Empowered for Success program in Southern Arizona which provides teens with an opportunity to engage in leadership training with development of plans to improve their school environments. This program targets adolescents in Southern Arizona.
- Training for first responders, teachers, parents, and community members in problem identification and referral to services. These trainings took place throughout Arizona and were targeted to persons who are first responders such as police and fire department professionals.

The deaths of several children in the child welfare system prompted the Governor to reform the system. Annually over 6,000 Arizona children were removed from their homes because of abuse or neglect perpetrated by their parents or guardians, with substance abuse cited as a factor in up to 80% of such removals. The prevention system continued to target communities with high indicators of abuse and neglect to address substance abuse at the protective and risk factor level, in at risk families and communities with young children.

- **Community Service Agencies**

The BSATP chief conducted a workshop during the 2003 ADHS Prevention Providers Conference to assist agencies in understanding the differences between prevention strategies and support services and the requirements for registering and delivering services as Community Service Agencies.

FY 2005 (Progress):

OBJECTIVE:

Maintain budget and allocation controls to conform to the "20% rule".

ACTIVITIES :

- Monitor implementation of Block Grant requirements using existing reports and controls.
- Conform to requirements in preparing contract allocation logs.
- Oversee distribution of funds in contract.
- Develop and implement a social marketing and education campaign to increase awareness of the connections between substance abuse and suicide risks.
- Finalize and distribute the revised Prevention Framework for Behavioral Health.
- **Monitoring**

Arizona prevention programs served over 200,000 people during FY 2005. ADHS/DBHS issued a request for proposals for Regional Behavioral Health Authorities serving all of the counties in Arizona, except for Maricopa County. Awards were made to three Regional Behavioral Health Authorities. Northern Arizona Regional Behavioral Health Authority will continue to provide services in the Northern Arizona Counties. Community Partnership of Southern Arizona will continue to provide services to the Southern and Eastern Counties. Cenpatico Behavioral Health will begin serving the Central and Western rural counties in place of the EXCEL Group and Pinal Gila Regional Behavioral Health Authority who served these communities prior to July 1, 2005 when new contracts went into effect.

Cenpatico, along with Division staff, conducted site visits to all providers in Pinal, Gila, La Paz, and Yuma Counties. The purpose of the visit was to assess appropriateness of the existing programs for funding in the 2005-2006 state fiscal year. As a result of these visits, several programs were discontinued due to a lack of conformity to evidence based practice and lack of demonstrable success. Cenpatico is providing extensive technical assistance to providers to help them to develop the successful, evidence based programs as well as to improve their use of strategies such as environmental and community based process.

Division staff conducted program level site visits to at least one program in each region. Regional Behavioral Health Authority staff selected most programs that were visited.

All Regional Behavioral Health Authorities with the exception of Value Options participated in formal administrative reviews. Three of the RBHAs, Community Partnership of Southern Arizona, Northern Arizona Regional Behavioral Health Authority, and Gila River Health Care Corporation were found to be in full compliance with all prevention standards. One RBHA, Pinal Gila Behavioral Health Association was found to be in compliance, but received a slightly lower score because they were unable to demonstrate that programs targeted high need, low resource populations. The EXCEL

Group and Pascua Yaqui Centered Spirit programs were found to not be in compliance with prevention standards. Both organizations were asked to submit corrective action plans, which were monitored throughout the year.

Value Options issued a new request for proposals for prevention programs in Maricopa County. Twenty new contracts were put into effect on July 1. Proposals were evaluated based on conformance with the DBHS vision outlined in the *Framework for Prevention in Behavioral Health*, for financial viability, and for past performance. Many providers selected for funds were new to the Value Options prevention system. Value Options hosted an orientation for new providers in June, at which contractual expectations were articulated.

Division staff reviewed financial reports with RBHA prevention coordinators intermittently throughout the year both in monthly prevention coordinator meetings and in person. Division staff reviewed with RBHA staff how funds were being applied to direct services vs. indirect costs.

- **Information Dissemination**

It is estimated that over 65,000 people will be reached by public information and social marketing strategies this year.

In Payson, the Rim Guidance Center conducted extensive public information and social effort in the early fall to raise awareness about substance abuse, suicide, and community resources. Venues included radio, newspaper, and art activities. The target population was all residents of Payson.

Community Partnership of Southern Arizona will be kicking off a "Make Meal Time Family Time" campaign targeting elementary students in Southern Arizona to build protective factors related to family attachment and bonding. The target population is families of elementary school aged youth in Southern Pima County.

Pinal Gila Center for Senior Citizens developed and distributed a behavioral health resource directory for medical professionals in Pinal and Gila Counties. The target population for this effort are medical professionals who serve older adults.

- **Problem identification and referral**

It is estimated that 5,000 people will have participated in problem identification and referral activities this year. Prevention professionals identified individuals throughout the course of prevention program implementation. Also, providers, RBHAs and Division staff provided screening and referral for behavioral health problems during National Alcohol Screening Day and National Depression Screening Day. Target populations for these events were the community at large.

- **Education**

It is estimated that 20,000 people will have participated in educational activities this year.

In Pinal and Gila Counties, the Pinal Gila Council for Senior Citizens developed a new educational program targeting primary care providers. The program educates medical staff about behavioral health issues in the older adult population with a focus on substance abuse. The project was able to show an 11% increase in provider awareness of the link between substance abuse and mental health disorders. The target population for this effort is medical professionals who serve older adults.

Northern Arizona Regional Behavioral Health Authority is planning a prevention summit for Northern Arizona Tribes in September. Over 300 participants are expected. A grant writing and fund raising workshop has been organized to take place one month after the summit. Thirty-five residents of Northern Arizona participated in a Prevention Planning forum. The target population for this project is Native Americans who reside in Northern Arizona.

Multiple prevention providers in Pinal and Gila Counties collaborated with one another and with local teen pregnancy prevention, parenting, and substance abuse coalitions to implement teen mazes in each county. Each maze was a three dimensional game in which youth learned information about health and wellness, substance use, decision making, and consequences associated with early sexual involvement. Approximately 600 youth across each county participated in these events. The target population is adolescents who reside in Pinal and Gila Counties.

In response to high rates of substance abuse related suicide in Arizona, the Phoenix Indian Center enhanced their existing parent support program with information about problem identification and referral to local resources. The target population for this effort is Native Americans who live in Maricopa County.

The EXCEL Group hosted trainings across Yuma and La Paz Counties related to substance abuse and suicide. Trainings were attended by community members as well as other non-profit and local governmental organizations. The target population is professionals who work with youth.

During the past year, the San Carlos Apache Tribe had a rash of completed suicides. Also, drug and gang related violence continued to be a problem. To address these issues, the San Carlos Apache Wellness Center developed a comprehensive, multi-pronged prevention program which included: formation of a prevention coalition, sponsorship of gender based retreats which combine prevention education with art and spiritual development, community educational forums, art contests, a wellness conference, gatekeeper education, development of a peer education program, and

distribution of social marketing messages via billboards, radio, cable TV, and newspaper. The target population for these efforts is members of the San Carlos Apache Tribe.

- **Environmental**

Pima Prevention Partnership in Pima County led the Tucson/Pima County Commission on Addiction Treatment and Prevention in authoring a report on underage drinking in Pima County. As a result of the report and other environmental efforts on behalf of the Commission, the Pima County Board of Supervisors voted to establish a task force on underage drinking. The Commission also proposed a tax on liquor sales to raise money for prevention of underage drinking. The target population for this effort is youth in Pima County.

In Tucson, Luz Social Services worked with a local coalition to not only protest new liquor licenses, but also to object to billboards advertising liquor in their neighborhood. As a result of their actions, the numbers of billboards in their community that advertise alcohol have declined dramatically. The target population for this project is residents of a low-income community in Tucson.

The Community Partnership of Southern Arizona continues to require each provider region wide to target changes in laws and norms supporting substance abuse. Several coalitions in Southern Arizona have had success in addressing this issue.

- **Community based process**

Arizona providers, RBHAs, and state prevention professionals participated in over 125 community, region, and state coalitions.

In Payson, the Rim Guidance Center chaired the Northern Gila County Community Prevention Council and participated in the Community Outreach Coalition. The target population is residents of Payson.

The Pima Youth Partnership's T-Himdag program mobilized five districts in the Tohono O'Odham Nation to assess the need for substance abuse prevention and assist in the development of a prevention program. The anti-drug coalitions formed in each district determined their communities were in the heart of an important drug smuggling corridor. Over 107,000 pounds of narcotics were captured by law enforcement. O'Odham police made 209 major arrests with the majority of those arrested being tribal members. Pima Youth Partnership helped the coalitions to develop youth leadership programs, organize community workshops on substance abuse, and implemented Botvin's Life Skills curriculum in local schools. The coalitions asked police to take more action to enforce youth curfews and party permits. As a result of their action, reports to the police of illegal drug activity and bootlegging increased, and coalition members felt like they were better able to

influence community conditions and solve community problems. The target population for this project is residents of the Tohono O'Odham Nation.

In May, Arizona's Governor, Janet Napolitano facilitated a summit with Tribal leaders to discuss the problem of substance abuse among Native American populations. The summit involved presentations from the state agencies addressing costs of substance abuse, trends in use, the public treatment system, and integration of best practices with traditional healing. The target population for this summit was Tribal leaders.

On the Navajo Nation, the Navajo Nation Division of Behavioral Health Services in collaboration with the Indian Health Services, Police, and community members formed a community coalition to address a sudden increase in admissions to the hospital in which methamphetamine was a factor, as well as the number of persons admitted to jail who tested positive for methamphetamine. The coalition filmed a documentary about methamphetamine among tribal members entitled "'G' Methamphetamine on the Navajo Nation". The documentary, which won an award at a national film festival, was shown throughout the nation at schools, businesses, and community centers in combination with educational presentations. The coalition also created a series of billboards with anti-methamphetamine messages, which were posted throughout the Nation. Finally, the group encouraged the Council to pass a law, which makes distribution and possession of methamphetamine on the reservation a criminal act. The target population is all residents of the Navajo Nation.

○ **Alternatives**

It is estimated that approximately 20,000 people participated in alternatives activities.

The Community Partnership of Southern Arizona (CPSA), in collaboration with each of the providers in Southeastern Arizona, implemented for a second year the Youth Educated for Success program in July 2005. Over 160 youth from 22 high schools participated. This is a youth leadership project in which teams of youth learn about prevention concepts and develop strategies for improving their school climate. CPSA staff participated in a service to science institute sponsored by the Western Centers for Applied Prevention Technology and are working to improve the evaluation for eventual introduction to the NREP process. The target population for this event is teens in Southern Arizona.

The Gila River Health Care Corporation commenced a peer education program in April 2005. The target population of this effort is Akimel O'Odham teens.

- **Conform to requirements in preparing contract allocation logs.**

The Division maintains an Allocation Schedule that lists each of the Division's Grant year awards and amount of the award for each year. The spreadsheet calculates the set aside amounts for HIV, Administration, Pregnant or Parenting Women and Prevention by the set aside percentage (%). That amount is then divided between the RBHAs both historically and then if there is an increase/decrease, by the percentage of population or other means.

- **Oversee distribution of funds in contract.**

The Division Finance Office ensures 100% of the allocation is paid out for each of the Block Grant set-asides. The Finance Office compares the Allocation Schedule and SAPT Block Grant year, to make sure that AFIS (Arizona Financial Accounting System) matches each set aside category.

- **Social Marketing/ Public Information Campaign**

Northern Arizona Regional Behavioral Health Authority conducted marketing research in partnership with several tribes in Northern Arizona. The research was used to develop a wellness campaign called Embrace Life in which information regarding wellness, problem identification and referral targeted to Native American populations will be distributed throughout Northern Arizona. The target population will be Native Americans who reside in Northern Arizona.

Community Partnership of Southern Arizona completed a series of focus groups to inform the design of a public information/social marketing campaign targeting older adults. The campaign will focus on problem identification and referral. The target population of this will be adults aged 55 and older.

- **Revised Prevention Framework for Behavioral Health**

The revised *Framework for Prevention in Behavioral Health* was published and distributed to providers and Regional Behavioral Health Authorities at the provider meeting in June 2005. The document outlines goals for capacity building within the provider network, strategic directions for program development, new program standards, new contract requirements, and new cultural competency requirements.

OBJECTIVE:

Ensure prevention professionals meet state competency requirements as outlined in the revised Prevention Framework for Behavioral Health.

ACTIVITIES:

- Develop training related to the three levels of professional competencies outlined in the revised Prevention Framework for Behavioral Health.
- Develop a system for monitoring prevention staff competencies.

- Develop formal training for professionals on design and implementation of a community needs assessment, elements of evidence-based practices, adapting best practice curricula, aging populations and Native Americans.
- Provide training and technical assistance to Arizona tribal prevention providers.

- **Training related to the three levels of professional competencies**

Division staff revised the Basic Skills training to align better with the professional competencies outlined in the *Framework for Prevention in Behavioral Health*. The revised curriculum was piloted with a group of providers from throughout the state in winter, 2005. Further revisions were made to the curriculum based on that training. A training of trainers is being planned.

Northern Arizona Regional Behavioral Health Authority is adapting the curriculum for an electronic learning format.

- **Monitoring prevention staff competencies**

Requirements for monitoring staff competencies were presented in the revised *Framework for Prevention in Behavioral Health*. Requirements are as follows:

- T/RBHAs have written contracts with all subcontractors used to provide prevention services. Subcontracts contain specific provisions, which incorporate by reference the ADHS Framework for Prevention in Behavioral Health and SAPT Block Grant.
- RBHAs conduct one visit to each prevention provider each year, with additional visits as needed. Site visits include interview(s) with program staff, observation of program activity, and review of training and supervision records. T/RBHAs and Tribal Contractors must participate in at least one site visit by DBHS staff annually and other visits as requested.
- RBHAs formally evaluate the quality of each prevention program in their network once annually.
- RBHAs provide written feedback to prevention programs at least once annually noting successes and providing recommendations for improvement.
- RBHAs keep copies of provider developed curricula on file.
- T/RBHAs and Tribal Contractors have on file a written description of each prevention program implemented in their region.
- RBHAs have a written evaluation plan for each prevention program, which is updated annually.

- **Needs assessment, evidence-based practices, adaptation, aging, and Native Americans**

The statewide Prevention Provider Meeting was an important venue for training providers in critical topic areas such as needs assessment, evidence based practice, program adaptation, and underserved populations. The Meeting held in June 2005 provided training

in all of these topics as well as an orientation to the revised *Framework for Prevention in Behavioral Health*.

Two of the Regional Behavioral Health Authorities have been working with providers targeting older adult populations to help the programs conform more to evidence based primary prevention practice. Providers in these regions will replace home-based prevention programming with strategies including peer education, gatekeeper education, senior center based programs and cross age mentoring. Language inclusive of older adult programs was included in the revised *Framework for Prevention in Behavioral Health*. Training pertaining to implementation of cross age mentoring programs was provided at the Prevention Provider meeting in June 2005.

Two all day training sessions were offered to prevention providers who were adding suicide prevention components to their substance abuse prevention programs. Training included evidence based strategies and social marketing.

As described below, considerable outreach to tribes and programs serving Native American populations has taken place over the past year.

The Border CAPT provided training for providers in Yuma on Border Binge Drinking prevention in May 2005.

- **Training and technical assistance to tribal prevention providers.**

The Division increased efforts to provide technical assistance and training to Tribes and prevention programs, which serve Native American populations. Division staff provided training in basic prevention skills for staff at the Pascua Yaqui Centered Spirit program and San Carlos Teen Wellness Center. The Division provided funds to the Hopi Nation to host a Drug Summit and a Methamphetamine Conference in collaboration with the Navajo Nation.

Division staff visited with staff from the Colorado River Indian Tribes and Navajo Nation to discuss prevention funds and plan for programs over the coming year.

Division staff facilitated the Native American subcommittee of the Suicide Prevention Coalition. The Division provided funds for the committee to receive training twice over the past year in topics including community needs assessment, strategic planning, evidence based practices, and program adaptation for culture.

This year will be the first time that the Division has received process evaluation data from all TRBHAs and Tribal Contractors.

OBJECTIVE:

Enhance the evaluation capabilities of programs contracted with the RBHAs.

ACTIVITIES

- Require use of core measures for evaluation as relevant to the program.
- Use alternative outcome evaluation measures when core measures are not relevant to the program.
- Develop a method for compiling state core measures data for compliance with National Outcomes Measures requirements.

All programs are asked to use one or more of six core measures to evaluate their programs. These measures are: perceived harm, attitudes toward substance use, parental positive reinforcement and affection, sense of community, and 30 day substance use. If no core measure is relevant to their population, they are permitted to use an alternative evaluation. The new evaluation format asks providers to report which core measures they are using and report outcomes as they relate to targeted risk and protective factors. The percentage of programs that are able to report outcomes has increased as a result of technical assistance and monitoring from RBHAs to providers.

Community Partnership of Southern Arizona is now compiling evaluation data from all programs into a summary region level evaluation. Using this process, they are showing changes in several protective factors.

Northern Arizona Regional Behavioral Health Authority has stopped funding providers who have not been compliant with evaluation expectations.

In March 2005, Division and RBHA staff met with the West CAPT and Border CAPT to discuss needs for technical assistance related to evaluation. Needs for the following types of training were articulated: evaluation training of trainers, evaluation training for evaluators, logic model training, assessing community readiness, needs assessment training, and tools for assessing the cultural competence of an organization.

OBJECTIVE:

Increase RBHA and provider use of evaluation and social indicator data to improve prevention programs.

ACTIVITIES:

- Produce a statewide summary evaluation of prevention programs.
- Distribute results of the 2004 Arizona Youth Survey.
- Collaborate with the Governor's Practice Improvement Committee to develop guidelines for Arizona prevention programs, which will be implemented across state agencies.

The Division has been actively involved in the State Epidemiology Work Group. Two health department epidemiologists have led the analysis of statewide data related to substance abuse. To date, the community has completed an exhaustive collection and

review of all existing data related to substance abuse in Arizona. Data collected includes: Arizona Youth Survey data, motor vehicle accident data, law enforcement data, vital statistics, death reports, child abuse, and emergency room data. As possible, data has been analyzed on regional and county levels in addition to state level. Inappropriate use of alcohol by young adults and adolescents (use of alcohol by minors and binge drinking) appear to be the most urgent problem related to substance abuse in the state followed by use of illicit substances by adolescents and young adults. The Epidemiology Work Group has developed a comprehensive summary of the data and will make recommendations to the State Incentive Grant Advisory Committee for final determination of priorities.

- **Summary evaluation of prevention programs**

A summary of evaluation outcomes was prepared for the Arizona Drug and Gang Policy Council. Program outcomes were organized by risk and protective factor. It was found that many providers had inconsistencies between assessed need, program goals and objectives, program strategies, and outcomes reported. Although logic model training was offered extensively in previous years, a need for better training in logic model has been identified.

- **2004 Arizona Youth Survey distribution**

Results of the 2004 Arizona Youth Survey were distributed electronically via the prevention provider list serve. Use of the results in assessment of need was reinforced during training for providers at the annual meeting in June 2005.

- **Collaborate with Governors Office to develop guidelines for prevention**

The Governor's Drug and Gang Policy Council was discontinued in the spring, 2005, and collaboration on a state level for substance abuse prevention was shifted to the State Incentive Grant Advisory Committee. The Council developed a set of guidelines regarding evidence-based treatment and prevention, and all prevention programs were compared against the guidelines to determine how closely they align. Goals for improvement were established and include increasing cultural competency and documentation of professional supervision.

FY 2006 (Intended Use):

OBJECTIVE:

Maintain budget and allocation controls to conform to the "20% rule."

ACTIVITIES:

- Monitor performance related to Block Grant requirements using existing reports and controls.
- Conform to requirements in preparing contract allocation logs.
- Oversee distribution of funds in contract.

OBJECTIVE:

Enhance network capacity to reduce risk factors associated with substance abuse.

ACTIVITIES:

- Continue to participate in the Epidemiology Work Group.
- Facilitate a statewide prevention coalition for tribal prevention providers.
- Monitor RBHA implementation of needs assessment and targeting of underserved groups with high risk factors for substance abuse.
- Develop or facilitate provision of training related to the advanced and administrative levels of professional competencies as outlined in the revised Prevention Framework for Behavioral Health Services.
- Provide or facilitate provision of trainings for providers in social marketing methods, cultural competency and adapting evidence-based practices for at-risk populations, and environmental approaches.
- Provide training and technical assistance to providers serving Native American populations in logic model development, program evaluation, needs assessment, and methamphetamine prevention, evidence based practices, and culturally based programming.
- Track professional competence via the annual evaluation report.
- Monitor competency, supervision, and training of prevention providers via Regional Behavioral Health Authorities and the annual evaluation report.

OBJECTIVE:

Enhance the evaluation capabilities of programs contracted with the T/RBHAs.

ACTIVITIES:

- Collect and compile National Outcome Measures from results of statewide evaluations.
- Identify providers that need technical assistance around evaluation and provide training to them on collection of and communication about outcome data.
- Produce and distribute an annual DBHS prevention system evaluation report.

OBJECTIVE:

Improve the quality of prevention program implementation.

ACTIVITIES:

- Monitor provider compliance with CLAS standards 4-7.
- Monitor provider compliance with the evidence-based guidelines for prevention developed by the Governor's Practice Improvement Committee.
- Establish a schedule to conduct site visits to all providers over the course of two years, including the provision of written feedback to providers and T/RBHAs.
- Monitor provider and RBHA involvement in coordination of local prevention services, using data from annual evaluation reports.

OBJECTIVE:

Decrease risk factors associated with substance abuse.

ACTIVITIES

All services will be provided by behavioral health agencies contracted with Regional Behavioral Health Authorities. Regional Behavioral Health Authorities hold contracts directly with the Arizona Department of Health Services. All programs in the table below will operate between October 2005 and June 30, 2006. Programmatic changes may be made for the period of July 1 to September 30, 2006.

Target populations	Estimated number of persons to be served	Activities/ Services to be provided	Location of services
Parents	400	Strengthening Multi-ethnic Families	Tucson; South Tucson, Chandler, Maricopa County
	200	Strengthening Families	Rural Pima County, Scottsdale
	200	Guiding Good Choices	Avondale; Phoenix
	100	Systematic Training for Effective Parenting	Maricopa County
	200	Active Parenting	Maricopa County, Scottsdale
	200	Parents who Care	Scottsdale, Maricopa County
	100	Common Sense Parenting	Prescott
African American Parents	100	Effective Black Parenting	Phoenix
	100	Families in Action for Teens	Phoenix
Hispanic Parents	100	Los Ninos Bien Educados	Phoenix
	100	Families in Action for Teens	Phoenix
	100	Sembrando Salud	Scottsdale
Parents of children ages birth to 5	200	Love & Logic	Cochise County; Prescott
	100	First Steps	Yavapai County
Refugee and new immigrant families	20	Strengthening Multi-ethnic families	Tucson, Scottsdale
Homeless families	20	Botvin's Life Skills	Maricopa County
	20	Strengthening families	Maricopa County
K-3rd grade students	2,500	Second Step	Apache Junction, Maricopa County
	100	Alternatives	Yavapai County
	100	Education, Information Dissemination	Flagstaff
Native American Elementary Students	50	Too Good for Drugs	Maricopa County
4th and 5 th graders	50	PATHS	Altar Valley
	300	Botvins Life Skills	Tohono O'Odham Nation; Gila River Indian Community, Chandler
	50	Smart Moves	Scottsdale
	2,000	Second Step	Apache Junction; Maricopa County
	200	Project Alert	Prescott; Maricopa County
	50	Across Ages	Phoenix, Avondale
	200	Too Good for Drugs	Tempe, Phoenix
	1000	Information Dissemination	Flagstaff
	100	Alternatives	Yavapai County
	200	Education,	Flagstaff; Prescott
Families	25,000	Education and Information Dissemination	Pima, Santa Cruz, Cochise, Graham, and Greenlee Counties, Mohave County, Navajo County, Apache County, Yavapai County, Coconino County
	300	Families and Schools Together	Concho, Springerville, Eager, Page, Flagstaff, Williams, Phoenix
	300	Active Parenting	Concho, Springerville, Eager, Page, Flagstaff, Williams
Community members	5000	Public Information; Environmental	Pima County; Gila River Indian Community; Colorado River Indian Tribes, Navajo Nation; Apache Junction
	200	Education	Pinal and Gila Counties
		Mobilizing for Change on Alcohol	Tucson
	20	Education	Tucson
	100	Community based process	Tucson, Pima County; Gila River Indian Community; Colorado River Indian Tribes, Navajo Nation; Apache Junction
Caregivers of older adults	500	Education, Community Based Process,	Pima County, Santa Cruz County, Cochise County,

		and Information Dissemination	Graham County, Greenlee County, Pinal County, Gila County
6th- 8th Grade Students	100	Information dissemination, community based process	Gila River Indian Community; Pascua Yaqui
	100	Alternatives	Gila River Indian Community; Pascua Yaqui, Maricopa County
	50	Discover Skills for Life	Guadalupe
	100	Education	Gila River Indian Community; Pascua Yaqui, Prescott
	100	Botvin's Life Skills	Gila River Indian Community, Chandler
	300	Too Good for Drugs	Tempe, Phoenix, Maricopa County
	100	All Stars	Tempe
	2,000	Project Alert	Prescott, Maricopa County, Phoenix
	100	Resolving Conflict Creatively	Phoenix
	100	Keepin it real	Maricopa County
	100	Second Step	Apache Junction
Native American Middle School Students	30	Alternatives, Education, Information Dissemination	Maricopa County
High school students	400	Alternatives	Pima County, Santa Cruz County, Cochise County, Graham County, Greenlee County, Chandler
	100	Community Based Process; Environmental	Pima, Santa Cruz, Cochise, Graham, and Greenlee Counties
	100	Too Good for Drugs	Tempe, Phoenix
	100	Keepin it Real	Maricopa County
	40	Reconnecting Youth	Page
GLBT Teens	50	Alternatives; Education; Community Based Process	Tucson
Teenage African American boys	20	Dare to be King	Phoenix
	20	Free the Horses	Phoenix
Young Native American Adults	40	Alternatives, Education, Information Dissemination	Maricopa Co unty
All youth	50	Alternatives, community based process	Holbrook
School staff	20	Education	Page
Child care providers	20	Incredible years	Maricopa County
Grandparents	20	Love & Logic	Prescott
	20	Common Sense Parenting	Prescott
Older adults	100	Education	Pinal County, Gila County, Yavapai County, Maricopa County
	100	Information Dissemination and Alternatives	Prescott
Health care providers serving older adults	20	Education	Pinal and Gila Counties

GOAL # 3. -- An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2003 COMPLIANCE

OBJECTIVE: Maintain budget, contractual and allocation controls to conform to the collective “10%” as part of the minimum expenditure requirement, so that providers of services to this special class of clients will have the opportunity to maintain past years increased capacities.

ACTIVITIES:

- (1) Ensure the Division’s Office of Business Operations continues to conform to objectives in preparing contract allocation logs.
- (2) Continue BSATP oversight of the distribution of funds in contract.
- (3) Expand the capacity of existing programs to make available treatment services for pregnant women and women with children.
- (4) Make available, directly or by referral, prenatal care and child care while women are receiving services.

COMPLIANCE:

- (1) **Contracts/Policy.** Vendor contracts were reviewed during the annual ADHS/DBHS amendment process to ensure appropriate contractual language is present that specifies expenditure and program requirements associated with this standard. The ADHS/DBHS initiated a review of a sample of vendor subcontracts with provider agencies during 2003 as part of the annual Administrative Review. The subcontract review verifies the presence of minimum subcontractor requirements related to this standard and others. BSATP staff also reviewed and approved a contract template for ValueOptions providers including case management standards and level of care criteria customized for pregnant women and women with children. All requirements for expenditure of the women’s MOE were detailed in the ADHS/DBHS Provider Manual, published in September 2003, and the RBHA Financial Reporting Guidelines.
- (2) **Expenditures/Funding.** Allocation methods and internal review processes remain in place and were used to insure the collective 10% funding was isolated in separate accounts on the Allocation Schedules for SFY 2003. The ADHS/DBHS Office of Business Operations has established effective budget controls and fiscal procedures to monitor the allocation and expenditure of funds for the women’s specialty program minimum requirements. BSATP participated in the 2003 spring review and analysis of current and upcoming fiscal year allocations with the Office of Business Operations to ensure proper distribution of funds.

(3) **Audits/Performance Reviews.** The Annual Operational/Financial Reviews were conducted in the fall 2003. No compliance issues were identified related to this standard. BSATP continued to review quarterly wait list data for pregnant women seeking access to treatment and provided feedback to RBHAs on expanding capacity and improving referral linkages between agencies.

Contract language incorporating new 100% FPL coverage for the TXIX behavioral health program and the Medicaid Covered Services expansion, added to RBHA contracts in 2001, included requirements for financial screening by behavioral health providers. BSATP staff monitored conversion rates for substance abusing women to the TXIX program to determine impacts on required expenditure levels for women under the SAPT Block Grant. BSATP staff provided technical assistance to the Maricopa and Pima county RBHAs in maintaining required expenditures, including expansion of outreach to non-TXIX women and families and provision of supported housing.

Quality Improvement. The BSATP met quarterly with RBHA Substance Abuse Coordinator staff to review progress in implementing and conforming with SAPT requirements for specialized services to women. Program monitoring tools based on the Core Components of Women's Treatment were drafted by BSATP in January 2002 and shared with the RBHAs to assist in managing and monitoring delivery of gender-specific treatment and services for children. Performance Improvement Plans were submitted by each RBHA in the summer of 2001 and continue to be used as tools to assist and support the RBHAs.

BSATP began to formalize the role of the Women's Treatment Coordinator during 2003. The Coordinator is now an identified BSATP staff with expertise in gender-specific and family services. The Coordinator piloted an on-site review process for women's programs in May 2003, using a cross-disciplinary team of DBHS staff and a standardized protocol based on the Core Components. The pilot review was intended to assess RBHA oversight methods for women's programs and to review clinical operations of the agencies themselves through interviews, program reviews and medical records. Findings and recommendations related to compliance requirements and service delivery are communicated back to the RBHA for further technical assistance.

In partnership with the Substance Abuse Coordinators from Value Options and CPSA, the BSATP chief provided a special workshop on gender-specific substance abuse treatment at the 2003 Summer Substance Abuse Institute. More than 60 persons attended the presentation on the evidence base for women's treatment, and programmatic implementation in Tucson and Phoenix.

(4) **Network Expansion.** Network Development Teams established by ADHS/DBHS in 2001 continued to assist and support the RBHAs in expanding their provider networks. BSATP staff participated on all five RBHA teams, establishing network expansion targets and providing RBHA-specific technical assistance on adding to the current network capacity. In addition, BSATP staff monitored conversion rates for substance abusing women to the TXIX program to determine impacts on required expenditure levels for women under the SAPT Block Grant. Currently, most services required in specialty programs for women are now compensable through TXIX. BSATP staff will work closely with ValueOptions and CPSA to ensure appropriate use of funds designated

for specialty women's programs, including expansion of engagement and outreach activities to non-TXIX women and families and use of non-traditional covered services.

The BSATP has produced several training tools to assist agencies in understanding how to use the new Covered Services/HIPAA codes to provide on-site child care services. This effort included collaboration with the Bureau for Children's Services and participation by BCS staff in the on-site women's program reviews.

Funding made available through increased Medicaid capitation and an increase to the SAPT Grant in 2002 and 2003 have resulted in significant expansions to network capacity for women with children, particularly in urban areas of the state. New services targeting pregnant/parenting women with children include:

Pinal Gila Behavioral Health Association

- PGBHA established a contract with specialty women's program in Tucson.

Northern Arizona Behavioral Health Authority

- NARBHA established a contract with a specialty women's program in Phoenix.
- NARBHA and its local contractor in Springerville established a supported housing facility for women with children referred through Child Protective Services that combines resources of HUD and the TXIX program. A second facility is being planned for the Show Low area.

Community Partnership of Southern Arizona

CPSA utilized the 2003 SAPT increase to enhance the infrastructure of the CPSA network for women's services across both regions.

- In Pima County, the Mother and Child Addiction Service (MCAS) team was established with the addition of a full-time MCAS Specialist at CPSA and full-time MCAS case management staff at each adult network. Services included targeted outreach, case management for substance abuse, behavioral health and primary health care. The MCAS program continued collaborative services with agencies and programs outside of the behavioral health arena to link women with community supports. MCAS provides linkages to support services for issues such as domestic violence, homelessness, nutrition and child health, as well as pre and post-natal care. Childcare services are available to women receiving group and individual counseling.
- In southeastern Arizona, CPSA engaged the services of Stephanie Covington, a nationally recognized expert on gender-specific treatment, to provide several trainings and local consultation and technical assistance for staff working with this population.
- CPSA worked closely with a woman's residential provider in Tucson to establish a contract with the TXIX adult networks in that area.

Value Options

- Value Options finalized arrangements to open Elba House, a 10 bed substance abuse residential facility for women and children owned and operated by Ebony House, a behavioral health provider specializing in services for the African American population in south Phoenix. This facility opened in January 2004.
- Community Bridges broke ground in October 2003 on a 24-bed residential substance abuse treatment and recovery support facility for women with young children (The

Center for Hope). The Center will provide wrap-around support services including vocational, parenting, mental health and substance abuse recovery services. The Bureau for Substance Abuse Treatment and Prevention Services received a Technical Assistance grant from the Center for Substance Abuse Treatment to assist in developing a clinical model for the center.

- The Value Options Pregnancy and Addictions Team began work with the clinical sites for adults with serious mental illness to coordinate services for pregnant consumers with mental illness. The case managers serve as special consultants to the SMI clinical teams to address special issues of pregnancy and substance abuse. VO is also undertaking a staffing assessment of the Pregnancy Team to ensure appropriate caseloads.
- ValueOptions utilized the SFY 2003 increase in the Substance Abuse Block grant to develop infrastructure necessary to more fully serve the TXIX/TXXI population including: purchasing a new van for the Pregnancy and Addictions Case Management Team, establishing a pool of six benefit specialists stationed at provider agencies and expanding existing contracts for intensive case management services to include this service for SAPT priority populations who are not TXIX eligible (e.g. women with children and injection drug abusers).
- Weldon House, located in Central Phoenix is a new supported housing service for substance-using women with children that opened in December 2003. The facility consists of six apartments for up to eight mothers and their children. There are no age limits on the children. The program is designed to provide a healthy, sober living environment that supports women in completing substance abuse treatment, obtaining employment and moving into permanent housing.
- Two new components, a vocational program and parenting education program have been added to the extensive array of services for pregnant women and children offered through New Arizona Family Inc.
- In December 2003, NOVA, a long-standing northwest Valley provider, opened a new, women-only wing in its Maverick House substance abuse residential facility. Treatment is anticipated to last between 30 to 45 days.

The BSATP continued to work closely with Arizona Families FIRST, the TANF-funded substance abuse/child welfare initiative established under Arizona Law in 2000. During SFY 2003, referrals from CPS caseworkers to the program continued to climb, in particular in Maricopa County. BSATP participated in several joint meetings and trainings of the RBHA Substance Abuse Coordinators, TXIX substance abuse agencies and Families FIRST contractors and state staff to ensure adequate coordination between the systems and efficient use of available funds. In response to the Governor's Action Plan for Reform of Arizona's Child Protection System released on September 2003, the BSATP re-directed \$1.5 million of SAPT Block Grant funds to support family-centered substance abuse treatment for parents referred from the CPS system in Maricopa and Pima counties.

FY 2005 (PROGRESS):

OBJECTIVE: Maintain budget, contractual and allocation controls to conform to the collective “10%” as part of the minimum expenditure requirement, so that providers of services to this special class of clients will have the opportunity to maintain past years increased capacities.

ACTIVITIES:

- (1) Ensure the Division’s Office of Business Operations continues to conform to objectives in preparing contract allocation logs.
- (2) Continue BSATP oversight of the distribution of funds in contract.
- (3) Expand the capacity of existing programs to make available treatment services for pregnant women and women with children.
- (4) Make available, directly or by referral, prenatal care and childcare while women are receiving services.

PROGRESS:

1) **Expenditures/Funding.** Allocation methods and internal review processes remain in place. The ADHS/DBHS Office of Business Operations has successfully ensured use of appropriate budget controls and fiscal procedures to monitor the allocation of the women’s specialty program MOE. BSATP participates in the review and analysis of current and upcoming fiscal year allocations with the Office of Business Operations to ensure proper distribution of funds.

2) **Contracts/Policy.** Vendor contracts were reviewed during the annual ADHS/DBHS amendment process in 2005 to ensure appropriate contractual language is present that specifies expenditure and program requirements associated with this standard. In addition, specific requirements are detailed in the following documents: RBHA Contracts, DBHS Provider Manual, RBHA Financial Reporting Guidelines.

BSATP staff met specifically with ValueOptions in April, June and July 2005 to review their contracting plan for allocation of SAPT Grant funds. A final plan for 2006, approved in September 2005, establishes specific cost-center thresholds for a variety of SAPT priority programs, including women’s MOE, supported housing and peer support specialists. Women with children are the primary population receiving services through these programs.

3) **Network Expansion.** Service capacity continued to increase in 2005 through growth in capitation, the 2004 SAPT grant increase and improved targeting of SAPT funds in ValueOptions’ network. Expansion activities included:

NARBHA:

- NARBHA has implemented gender-specific outpatient treatment and support groups for women in three northern Arizona communities: Kingman, Bullhead City, and Show Low. Development funds were targeted to areas with a high concentration of women with a substance abuse. Services include transportation, childcare and peer support.

VALUEOPTIONS:

- ValueOptions continues to provide a specialized case management program for the priority population. This specialized team is overseen by a nurse and consists of five case managers and a part time Psychiatrist. The team was expanded by 2 FTE during 2005 to accommodate increased growth in the population. This team ensures that pre-natal care is in place, and helps to engage women into treatment. The team typically follows women for six months after delivery.
- Peer support services are available at treatment facilities throughout the county and continue to be expanded to provide services at specialty programs for women with children. Current speciality women's providers with peer support staff include: Native American Connections, Center for Hope, Elba House, NCADD/Weldon House.
- ValueOptions added five new providers to expand the availability of supported housing services for women with children.
- The Center for Hope opened in January 2005. A specialty residential treatment facility for pregnant women, the Center has capacity for 24 women and 32 children/infants. The Center has received technical assistance and training for staff through CSAT TA and has provided services to 30 women from January August.

CPSA:

- The Mother and Child Addiction Service (MCAS) program used additional SAPT Block Grant funds to further expand their services in Pima county, including adding a women's resource center and three peer support staff.
- Grant funds were used to hire a MCAS Specialist to work with outpatient treatment sites in the four counties of southeastern Arizona.
- Peer/recovery support specialists are being developed to provide services to this priority population. Provider training and TA for all adult networks and NTXIX providers hiring peer/recovery specialists was delivered in 2005. Thirty-six peer workers had completed their internship practicum by August.
- CPSA is providing infrastructure support to develop a 9-bed level II residential facility for pregnant/post-partum with children in Bisbee. The facility is scheduled for opening in the winter 2005.
- CPSA continues to prioritize SAPT Block Grant funds to provide Arizona Families First services to parents referred by CPS.

EXCEL Group:

- EXCEL purchased the Hazelden co-occurring staff training program.
- EXCEL added four Level 2 treatment beds for a total of 14 beds available to women in Yuma.

PGBHA

- PGBHA expanded its network capacity in 2004-05 by subcontracting with two residential providers focused on substance abuse services to women and their children from out of region providers.
- PGBHA has participated in the ADHA/DBHS initiative to build peer and family support services within the substance abuse services continuum.

(4) **Quality Improvement.** BSATP staff developed a specialized coaching tool to monitor how agencies are providing referrals to prenatal care and childcare while women are receiving services. The coaching tool/sessions use a grand rounds model to support discussion on any potential barriers to providing these services. The Women's Treatment Coordinator developed a new wait list-tracking tool designed to better identify populations served and need for residential beds for pregnant and/or women with dependent children.

In partnership with the AZ Department of Economic Security/ Division of Children, Youth, and Families and the University of Arizona /Applied Behavioral Health Unit the BSATP Interagency Collaborator provided a workshop regarding the Arizona Families First Program at the 2005 Summer Substance Abuse Institute. Emphasis was placed on special considerations of providing services to families referred for substance abuse treatment by CPS.

FY 2006 (INTENDED USE):

OBJECTIVE: Maintain budget, contractual and allocation controls to conform to the collective "10%" as part of the minimum expenditure requirement, so that providers of services to this special class of clients will have the opportunity to maintain past years increased capacities.

ACTIVITIES:

1. Ensure the Division's Office of Business Operations continues to conform to objectives in preparing contract allocation logs.
2. Continue BSATP oversight of the distribution of funds in contract.
3. Expand the capacity of existing programs to make available treatment services for pregnant women and women with children.
4. Make available, directly or by referral, prenatal care and child care while women are receiving services.

Intended Future Development by RBHAs:

NARBHA

- NARBHA is partnering with community agencies to develop additional supportive housing options for SA women.
- Expand peer/recovery support specialists

ValueOptions

- Will continue and expand supported housing for SA women with children.
- Continue/expand existing peer/recovery support services.

CPSA

- Work plan is being developed with the primary goal of enhancing the response to this population, to assure any pregnant/post-partum substance-using women in GSA 3 can receive services based on best practices.

Attachment B: Programs for Pregnant Women and Women with Dependent Children (See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2003) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FY 2003. In a narrative of up to two pages, describe these funded projects.

Response:

Any residential or outpatient substance abuse agency in Arizona may provide services to a pregnant woman or a woman with dependent child. Demand for the “specialty women’s” environments, as detailed in the law, has grown enormously beginning in SFY 2001, in large part due to both the increase in Medicaid eligibility and the implementation of the Arizona Families FIRST program for TXIX eligible child welfare parents. The listing below indicates the “base” for specialty women’s settings available in SFY 2003. Arizona’s three rural RBHAs and the Gila River Indian Community TRBHA also contract for bed capacity in these facilities:

CPSA (Pima County; Graham, Greenlee, Cochise, Santa Cruz Counties)

CPSA contracts with two residential facilities offering the full continuum of “specialty women’s” services:

- The Haven : The Haven provides residential treatment in a home-like atmosphere for women with persistent AOD problems, particularly alcoholism. Children may enter the facility 30 days after admission by the mother.
- CODAC/Las Amigas: - Residential services in a 16-bed facility for pregnant/postpartum women with an average 14 youth in residence at any given time. An additional 8 beds were added in 2002 for a total of 24 beds.

Mother and Child Addiction Services (MCAS) – Beginning in 2001, CPSA undertook a utilization and capacity study of services for priority population women in Pima County and southeastern Arizona. CPSA operates a one-stop, outpatient service model for pregnant women and women with young children in both regions. While full development and expansion of the programs has occurred over a number of years, in 2002 the MCAS program opened in Pima County offering intensive case management and intensive outpatient counseling at a single delivery site staffed by clinicians from all three adult networks in Tucson. A Women’s Resource Center developed in 2003-04 also offers childcare and linkages to community support services for issues such as domestic violence, homelessness, nutrition and child health, as well as pre and post-natal care. In southeastern Arizona, CPSA provided specialized training in gender-specific treatment through a contract with Stephanie Covington and hired a region-wide coordinator for women’s services (2004).

ValueOptions (Maricopa County)

ValueOptions both directly delivers and contracts with specialty women's providers who deliver the full continuum of gender-specific care:

- New Arizona Family: New Arizona Family is a long-term residential treatment program serving women in the Phoenix area, including services to pregnant/post-partum women with/without co-occurring mental illness. Thirty beds are set-aside for pregnant and parenting women with additional sleeping arrangements for infants and children. Children's treatment, including therapeutic nursery services, is offered. Intensive outpatient and housing are available.
- Native American Connections: Guiding Star Lodge: This program provides residential alcohol and drug treatment to Native and non-Native women and their dependent children. Program modalities combine therapeutic approaches to treatment with cultural and spiritual approaches to healing, which include the use of the Sweat Lodge and Talking Circles. The residential program includes the following treatment themes: alcohol/drug education, relapse prevention, relationships and family issues, self concept and communication skills, emotions and anger work, assertiveness training and daily living skills, and spiritual/cultural empowerment. Capacity in FFY 2003 was 32.
- National Council on Alcoholism and Drug Dependence: Offers specialized, gender-specific services on an outpatient basis for up to 55 women and their children. In December 2003, NCADD opened a supported housing service for recovering women with children (Weldon House). The recovery housing program consists of six apartments accommodating eight mothers in treatment and their children. The program provides a healthy, sober living environment that supports women in completing substance abuse treatment, obtaining employment and moving into permanent housing.
- Casa de Amigas: This 10-bed facility focuses on early recovery needs of women. Children may enter the facility after the first 30 days.
- Value Options Pregnancy and Addictions Case Management Team: This specialized team of nurse case managers delivers outreach and engagement services, and targeted and intensive case management, transportation and coordination services for prenatal and well-baby care to all pregnant substance abusers in the ValueOptions network. Staff capacity in 2003 was 2.5 FTE case managers and 1 FTE nurse supervisor.

Attachment B (continued)

The PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), type of care (refer to definitions in Section II.5), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.
2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2003 block grant funds?
3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?
4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?
5. What did the State do with FY 2003 block grant funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

RESPONSE:**1. Specialty Women's Providers:**

Any residential or outpatient substance abuse agency in Arizona may provide services to a pregnant woman or a woman with a dependent child. Demand for the "specialty women's" environments, as detailed in the law, has grown enormously beginning in SFY 2001, in large part due to both the increase in Medicaid eligibility and the implementation of the Arizona Families FIRST program for child welfare parents. The listing below indicates the "base" for specialty women's settings available at the beginning of SFY 2003. Arizona's three rural RBHAs and the Gila River Indian Community TRBHA also contract for bed capacity in these facilities:

CPSA (Pima County; Graham, Greenlee, Cochise, Santa Cruz Counties)

CPSA contracts with two residential facilities offering the full continuum of "specialty women's" services:

The Haven (AZ750311)- The Haven provides residential treatment in a home-like atmosphere for women with persistent alcohol or drug (AOD) problems, particularly alcoholism. Children may enter the facility 30 days after their mothers' admission.

CODAC/Las Amigas (AZ105748) - Residential services in a 16 bed facility for pregnant/postpartum women with an average 14 youth in residence at any given time. An additional 8 beds were added in 2002.

Mother and Child Addiction Services (MCAS) –

Launched in the fall of 2003 CPSA operates a one-stop, outpatient service model for pregnant women and women with young children in both regions. While full development and expansion of the programs has occurred over a number of years, the MCAS program opened in Pima county offering intensive case management and intensive outpatient counseling at a single delivery site staffed by clinicians from all three adult networks in Tucson. The resource center also offers childcare and linkages to community support services for issues such as domestic violence, homelessness, nutrition and child health, as well as pre and post-natal care.

ValueOptions (Maricopa County)

ValueOptions directly delivers and contracts with specialty women's providers who deliver the full continuum of gender-specific care:

New Arizona Family (AZ101135)- New Arizona Family is a long-term residential treatment program serving women in the Phoenix area, including services to pregnant/post-partum women with/without co-occurring mental illness. Thirty beds are set-aside for pregnant and parenting women with additional sleeping arrangements for infants and children. Children's treatment, including therapeutic nursery services, is offered. Intensive outpatient and housing are available.

Native American Connections: Guiding Star Lodge (AZ750162) This program provides residential alcohol and drug treatment to Native and non-Native women and their dependent children. Program modalities combine therapeutic approaches to treatment with cultural and spiritual approaches to healing, which include the use of the Sweat Lodge and Talking Circles. The residential program includes the following treatment themes: alcohol/drug education, relapse prevention, relationships and family issues, self concept and communication skills, emotions and anger work, assertiveness training and daily living skills, and spiritual and cultural awareness. Capacity in FFY 2003 was 32.

National Council on Alcoholism and Drug Dependence: Offers specialized, gender-specific services on an outpatient basis for up to 55 women and their children. Added to these services is a new supported housing service for recovering women with children (Weldon House – Opened December 2003). The housing program consists of six apartments accommodating eight mothers and their children. The program provides a healthy, sober living environment that supports women in completing substance abuse treatment, obtaining employment and moving into permanent housing.

NOVA: In December 2003, NOVA, a long-standing northwest valley provider, opened a new women-only wing at its Maverick House substance abuse residential facility. Treatment is anticipated to last between 30-45 days.

Community Bridges: Community Bridges broke ground in October 2003 on a 24-bed residential substance abuse treatment and recovery support facility for women with young children (Center for Hope). The Center will provide wrap-around services including vocational, parenting, mental health, and substance abuse recovery services.

Ebony House Inc.: Ebony House is developing a 10-bed substance abuse residential facility for women and children (Elba House). Women will be able to begin entering the facility January 04. The facility will accommodate 10 women and up to 8 children ages 0-8.

Casa de Amigas: This 10-bed facility focuses on early recovery needs of women. Children may enter the facility after the first 30 days.

Value Options' Family Recovery Partnership: VO manages contracts with two substance abuse agencies for the Family Recovery Partnership, a specialized family-centered addictions treatment program for parents and children involved with Child Protective Services. VO staff provides case management and oversight of this pilot program and delivers services through Chicanos por la Causa and EMPACT. This program was merged with the SB 1280 TANF program in the spring 2002.

ValueOptions Pregnancy and Addictions Case Management Team: This specialized team of nurse case managers delivers outreach and engagement services, and targeted and intensive case management, transportation and coordination services for prenatal and well-baby care to all pregnant substance abusers in the ValueOption's network.

2. Funds required to be spent under 42 U.S.C. 300x-22(c)(1)(C) were identified and special cost centers established on the DBHS Allocation Schedules to track the cumulative minimum required expenditure as these funds went out in contract. Each Regional Behavioral Health Authority contract contained details of the allocations by specific accounts referenced in the Allocation Schedules. Information on expectations for program expenditures (e.g. gender-specific, case management, transportation, etc.) were also detailed in the RBHA contracts and the DBHS Provider Manual. The cumulative 10% derived from 2001 and 2002 SAPT Block Grants was tracked across two state fiscal years in order to assure the full amount was distributed during each 24-month expenditure period. Contract discussions were held with each RBHA to assure any distribution would be spent in accordance with applicable federal requirements. The amounts by RBHA and by drug and alcohol treatment are reported in item 5 (below).

3. RBHA expenditures for appropriate program services were tracked during annual site visit activities and through annual utilization and expenditure data. Corrective actions resulting from prior year site visits focused on priority placement mechanisms, wait list

management, network capacity, and program standards for women. In 2002, ADHS/DBHS also implemented a network capacity Logic Model that assesses data from multiple sources (e.g. complaints, customer satisfaction, enrollment, penetration, etc.) to determine the sufficiency of RBHA provider networks. SAPT wait lists were one element of the Logic Model analysis that resulted in the development of network capacity and growth targets in each RBHA.

In 2003 a DBHS introduced “mystery shopper” as a method of assessing the adequacy of provider response to clients that present who fit SAPT priority populations. In Pima County, a mystery shopper study was undertaken in response to concerns raised by ADHS-DBHS staff about possible difficulty clients in the priority population were having in accessing services. Simulated client requests for services were conducted by phone with adult providers in Pima County. Staff created a scenario reflective of their being pregnant, or potentially pregnant. Staff/callers were asked to record the results of their interview experience on a standardized call record. The call record included potential screening topics, which might be indicative of an agency’s thoroughness in screening for priority populations, and when identified, assisting such clients in accessing needed services in a timely manner. Recommendations were provided to improve services to this population.

A walk through of the Women’s Addiction Treatment System was conducted in Maricopa County in May 2003 for similar reasons. The purpose of the walk through was to provide technical assistance and support to agencies as well as to determine how agencies/RBHAs assure that priority populations receive appropriate and timely services. In northern Arizona, excessive wait lists for residential treatment led BSAPT to require NARBHA to conduct a quarterly record review of all admissions to substance abuse residential facilities to ensure timeframes for priority populations and TXIX members were met. The review began in October 2003 and ended in January 2005. Findings were used to provide technical assistance to one agency in particular and were incorporated into the NARBHA network development plan for 2005.

4. DBHS uses a variety of mechanisms to estimate capacity and monitor utilization. RBHA compliance with the women’s minimum expenditure requirement in SFY 2001-2002 was monitored through an annual service utilization and expenditure test using data from both the claims and assessment databases. The Client Information System, as modified for conformity with the federal client data system, contains Special Population fields to identify Pregnant Women and Women with Dependent Children, which are used to extract service utilization and expenditure information. Treatment capacity is estimated annually through surveys of substance abuse provider agencies conducted to develop the RBHA Network Development Report. Quarterly wait lists are compiled by each RBHA using data collected by subcontracted providers. The wait lists monitor both the 48-hour placement standard and the provision of interim services. These data are analyzed in preparing the RBHAs annual network development plan.

During SFY 2003, the DBHS continued work toward development of a data-driven network capacity and utilization method, known as the Arizona Logic Model. This approach will be used in future years to provide improved information about needed capacity for the specialty women’s program and services.

5. A specific allocation from the 2003 Block Grant, in addition to other funds spent by RBHAs for pregnant and parenting women's treatment services, was distributed according to the table below. The DBHS chose to use funds set aside from the 2003 award to maintain the existing base of specialty contractors and services. System enhancements due to the SAPT increase for that year included infrastructure funding in Maricopa county, expansion of the Pima County MCAS program and funding for development of the NCADD Weldon House supported housing facility.

Contractor	2003 Substance Abuse Block Grant.
EXCEL	\$40,684.00
ValueOptions	\$1,980,811.00
CPSA (Regions 5&3)	\$731,952.00
NARBHA	\$113,566.00
PGBHA	\$54,087.00
Total	\$2,921,100.00

GOAL # 4.-- An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FY 2003 (COMPLIANCE):

OBJECTIVE: Providers serving injection drug abusers will notify the RBHA upon reaching 90% capacity.

ACTIVITIES:

- (1) Ensure inclusion of appropriate language in subcontracts and the DBHS Provider Manual.
- (2) Participate in DBHS Network Analysis and Development Team process to develop tools and models for ensuring the sufficiency of the RBHA provider network for injection drug abusers.
- (3) Participate in annual Administrative Review of RBHAs to monitor performance and issue corrective action/sanctions as appropriate.

OBJECTIVE: Providers serving injection drug abusers will provide interim services for individuals wait-listed for more than 14 days.

ACTIVITIES:

- (1) Participate in DBHS Network Analysis and Development Team process to develop tools and models for ensuring the sufficiency of the RBHA provider network for injection drug abusers.
- (2) Continue RBHA technical assistance on quarterly wait list data collection and uses of the data to analyze network capacity.
- (3) Conduct cross-system training for probation staff in Maricopa county.

COMPLIANCE

(1) **Contracts.** Contract language for the RBHAs continued to reflect requirements related to provider notification, outreach services for injection drug users and wait list/interim service requirements for users who cannot be admitted within 14 days. Standards are also detailed in the ADHS/DBHS Provider Manual.

(2) **Audits/Performance Reviews.** Quarterly wait lists detailing time frames for admission and delivery of interim services are collected for subcontracted providers serving injection drug abusers. During 2003, BSATP required quarterly wait list reports from ValueOptions, NARBHA and CPSA-Pima due to the growth in this population under the expanded TXIX program. Monitoring of SAPT wait lists in 2003 indicated that the number of IDUs waiting for services had increased in these regions, as did the number of days on the wait list. Staff reviewed the lists and provided RBHA-specific technical assistance on types of interim services provided and estimating need for expanded capacity.

BSATP staff continued to participate on RBHA Teams during 2003 and conducted the Annual Administrative Review. Each RBHA developed a specific policy for addressing program and financing requirements of the SAPT Block Grant during the SFY 1998 and 1999 Reviews. No corrective actions relevant to this standard were identified in 2003.

(3) **Quality Improvement/Network Expansion.** BSATP staff continued to participate in special Network Development Teams designed to support the RBHAs in identifying areas for network expansion based on data. Increased service demands related to the increase in FPL under Arizona's Medicaid program has driven the need to expand network capacity to serve injection drug abusers.

Specific development initiatives related to capacity needs for injection drug abuse in 2003 included:

Community Partnership of Southern Arizona

This RBHA established a performance improvement project in January 2003 for methadone capacity in Pima County. Monitoring of Block Grant wait lists indicated that the number of IDUs waiting for services increased in 2002, as did the number of days on the wait list. A Performance Improvement Protocol provided initial recommendations on alternatives to opioid treatment medication services and further development of infrastructure to serve additional members. (Ultimately, to better manage capacity needs, a contracted provider established a new opioid treatment program and began planning around an expansion in physician staff trained to provide buprenorphine.)

EXCEL Group

Continued to subcontract with a Yuma-based opioid treatment provider.

NARBHA

Numbers of consumers on wait lists for more intensive substance abuse services became problematic in SFY 2003, resulting in a special term and condition added to the this RBHAs contract. BSATP staff worked closely with NARBHA throughout SFY 2003-04 in two venues: (1) to establish a needs-based, individual-focused model for determining appropriate care placements using ASAM criteria; and (2) developing a specific case file review process to determine needed capacity for more intensive substance abuse services, including opioid treatment, residential and intensive outpatient. In the spring 2003, NARBHA released more than \$950,000 in additional TXIX funding for outpatient substance abuse services and \$150,000 for out-of-network residential beds.

Value Options

Medical detoxification services in Phoenix were placed under new management as the result of an RFP published by ValueOptions. The new contract included special provisions to ensure that members receiving methadone could continue their medication service while undergoing detoxification treatment. In addition, ValueOptions implemented a performance improvement project to continue provision of methadone medication for members admitted to Level 2 substance abuse residential facilities. Cross-

systems training for Maricopa probation staff was conducted throughout the fall under a CSAT-supported technical assistance request. ValueOptions also used a portion of the SFY 2002 Block Grant to promote intensive case management services for injection drug users and pregnant and parenting women.

FY 2005 (PROGRESS):

OBJECTIVE: Providers serving injection drug abusers will notify the RBHA upon reaching 90% capacity.

ACTIVITIES:

- (1) Ensure inclusion of appropriate language in subcontracts and the DBHS Provider Manual.
- (2) Modify notice requirements as appropriate based on negotiated performance improvement goals in the 2005 Performance Partnership Block Grant.

OBJECTIVE: Providers serving injection drug abusers will provide interim services for individuals wait-listed for more than 14 days.

ACTIVITIES:

- (1) Participate in DBHS Network Analysis and Development Team process to develop tools and models for ensuring the sufficiency of the RBHA provider network for injection drug abusers.
- (2) Continue RBHA technical assistance on quarterly wait list data collection and uses of the data to analyze network capacity.
- (3) Participate in annual Administrative Review of RBHAs to monitor performance and issue corrective action/sanctions as appropriate.
- (4) Modify notice requirements as appropriate based on negotiated performance improvement goals in the 2005 Performance Partnership Block Grant.

PROGRESS:

- (1) **Contracts.** Contract language for the RBHAs continued to reflect requirements related to provider notification, outreach services for injection drug users and wait list/interim service requirements for users who cannot be admitted within 14 days. Standards are also detailed in the ADHS/DBHS Provider Manual.

- (2) **Audits/Performance Reviews.** Quarterly wait lists detailing time frames for admission and delivery of interim services are collected for subcontracted providers serving injection drug abusers. During 2005, BSATP required quarterly wait list reports from ValueOptions, NARBHA and CPSA-Pima due to the growth in this population under the expanded TXIX program and initiated a process to better standardize wait list reporting across the regions. Monitoring of SAPT wait lists in 2005 continued to indicate that the number of IDUs waiting for services had increased in these regions, as did the number of days on the wait list. Staff reviewed the lists and provided RBHA-specific technical assistance on types of interim services provided and estimating need for expanded capacity.

BSATP staff continued to participate on RBHA Teams during 2005 and conducted the Annual Administrative Review. Each RBHA developed a specific policy for addressing program and financing requirements of the SAPT Block Grant during the SFY 1998 and 1999 Reviews. For 2005, EXCEL Group received a corrective action relevant to this standard and submitted a corrective plan.

(3) **Quality Improvement/Network Expansion.** BSATP staff continued to participate in special Network Development Teams designed to support the RBHAs in identifying areas for network expansion based on data. Increased service demands related to the increase in FPL under Arizona's Medicaid program has driven the need to expand network capacity to serve injection drug abusers.

Specific development initiatives related to capacity needs for injection drug abuse in 2005 included:

Community Partnership of Southern Arizona (CPSA)

- Enhanced opioid maintenance services for residents of Cochise, Graham, Greenlee, and Santa Cruz Counties by adding buprenorphine to the formulary, developing a buprenorphine protocol, and ensuring three physicians (including the network Medical Director) were authorized to provide buprenorphine.
- Enhanced opioid maintenance services for residents of Pima County by adding an additional outpatient opioid treatment site newly developed and operated by an existing service provider (COPE).

Gila River Indian Community

- Maintained capacity to serve injection opiate abusers by prescribing Subutex/Suboxone.

Pinal Gila Behavioral Health Authority (PGBHA)

- Added contract for additional opioid treatment with existing private provider.

ValueOptions (VO)

- Expanded opioid treatment services in both North and West Phoenix by expanding the contract of an existing methadone provider to establish two new sites capable of serving 425 new clients.

(4) **National Outcome Measures.** The BSATP collaborated with the DBHS Quality Management and Data Dissemination units to develop written data extraction protocols for developing production NOMs measures. The opportunity to negotiate performance goals and modify capacity notification and wait list requirements was not made available in 2005.

FY 2006 (INTENDED USE):

OBJECTIVE: Providers serving injection drug abusers will notify the RBHA upon reaching 90% capacity.

ACTIVITIES:

- (1) Ensure inclusion of appropriate language in subcontracts and the DBHS Provider Manual.
- (2) Modify notice requirements as appropriate based on negotiated performance improvement goals in the 2006 Performance Partnership Block Grant.

OBJECTIVE: Providers serving injection drug abusers will provide interim services for individuals wait-listed for more than 14 days.

ACTIVITIES:

- (1) Participate in DBHS Network Analysis and Development Team process to develop tools and models for ensuring the sufficiency of the RBHA provider network for injection drug abusers.
- (2) Continue RBHA technical assistance on quarterly wait list data collection and uses of the data to analyze network capacity.
- (3) Participate in annual Administrative Review of RBHAs to monitor performance and issue corrective action/sanctions as appropriate.
- (4) Modify notice requirements as appropriate based on negotiated performance improvement goals in the 2006 Performance Partnership Block Grant.

Attachment C: Programs for Intravenous Drug Users (IVDUs)
(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))

For the fiscal year three years prior (FY 2003) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?
2. What did the State do to ensure compliance with 42 U.S.C. 300x-23 of the PHS Act as such sections existed after October 1, 1992, in spending FY 2003 SAPT Block Grant funds (See 45 C.F.R. 96.126(a))?
3. What did the State do to ensure compliance with 42 U.S.C. 300x-31(a)(1)(F) of the PHS Act prohibiting the distribution of sterile needles for injection of any illegal drug (See 45 C.F.R. 96.135(a)(6))?
4. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2003 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).
5. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).
6. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

RESPONSE

1. The following definition was in use during the target fiscal year:
“If the client injects (intramuscularly, intravenously, or via ‘skin popping’) a non-prescribed substance (i.e., a diabetic injecting necessary insulin would not apply) on a regular basis, or has done so recently (i.e., within the last 30-60 days), the client should be considered an IV drug user. Clinical staff should judge whether IV drug use is a current problem for this client.” (CIS Demographic Data Definitions)
2. Contracts in place in 2003 between ADHS and RBHAs directed implementation, at the subcontractor level for the reporting requirement when 90% of capacity is reached. This information is also detailed in the ADHS/DBHS Provider Manual. The 2003 SAPT Block Grant funds were spent in SFY 2003 and 2004. Appropriate requirements

conforming to the details of Section 96.126(a) are present in contracts with RBHAs for those years and were discussed with RBHA management staff. The requirements were also incorporated into published Requests for Proposals (Maricopa County 2004) and Greater Arizona (2005) as well as included by reference in the DBHS Provider Manual (2004). Annual site visit protocols for those years tested for adherence to the standard required.

3. The requirement at 45C.F.R. 96.135(a)(6) was made part of contract language in the early 1990s and remains in place today. Contract restrictions on use of funds to distribute sterile needles are reviewed during periodic RBHA Substance Abuse Coordinator meetings. Agencies are aware that this restriction is limited to the use of SAPT Block Grant funds.

4. All contracts in place in 2003 between ADHS and RBHAs directed implementation, at the subcontractor level for the reporting requirement when 90% of capacity is reached. Specific contract language presented the requirements at 45C.F.R. 96.126(a) and the need to notify the RBHA when a subcontracted provider had reached 90% of its capacity to serve injection drug abusers. Providers regularly report surpassing 90% capacity. These data are incorporated into the Arizona Logic Model and are used to assess network sufficiency for opiate treatment services. (See Goals #1 and #13 for greater detail) The notification list for SFY 2003 includes both state supported methadone/counseling programs and residential substance abuse treatment programs serving injection drug abusers:

Outpatient Methadone:

- Valle del Sol (AZ100095; AZ902102)
- CODAC (AZ105599)
- La Frontera Center

Level II Residential Substance Abuse

- Chicanos por la Causa (AZ101093)
- The Guidance Center
- New Arizona Family (AZ101135)
- West Yavapai Guidance Center
- Calvary (AZ301487)

5. All contracts between ADHS and RBHAs for 2003 directed implementation, at the subcontractor level for the requirement injection drug abusers be enrolled in treatment within 14 days of the request for admission, or within 120 days from the request for admission if no program has the capacity available to admit the patient and if interim services are offered within 48 hours of the request for treatment. Specific contract language detailing the requirements of 45 C.F.R. 96.126(b) has been in place for many years and was incorporated into recent Requests for Proposals (Maricopa County 2004) and Greater Arizona (2005) as well as the DBHS Provider Manual (2004). The BSATP was made aware during the SFY 1998 Operational/Financial Review that the 14-day

requirement could rarely be met with the exception of admissions for Medicaid-eligible clients and this situation was the subject of performance improvement initiatives in Maricopa and Pima counties during 2003-2005. Wait lists for SAPT-funded members are collected by each RBHA for their subcontracted opioid treatment and residential providers. Wait list data from Value Options and CPSA (for Pima County providers) was submitted and reviewed directly by BSATP staff on a quarterly basis during 2002. NARBHA was added to the direct review list in SFY 2003. Annual Network Sufficiency and Development Plans submitted by the RBHAs include a review of wait list information in designing network expansion targets.

Specific opioid treatment capacity measures (agencies and “slots”) were collected through the first DBHS Provider Inventory in SFY 2002 and again in 2003. In Maricopa and Pima County, minimum network capacity measures for opioid treatment are part of the RBHA contract. The BSATP has promoted and enhanced interim services for non-TXIX clients who of necessity are wait listed for needed treatment services. These efforts include promotion of pre-treatment groups at residential drug treatment centers, establishing linkages with private-pay clinics and encouraging use of group health promotion services to enroll and bill for interim service delivery for IDUs. In addition, HIV Early Intervention agencies are specifically required to serve IDUs on wait lists as part of their interim service package.

IDUs who are enrolled under the state’s Medicaid program may not be placed on wait lists. These individuals, comprising more than 85% of all methadone clients by the end of SFY 2003, were provided admission to treatment within DBHS appointment standards for emergency (2 hours), urgent (24 hours) and routine (7 day) services. Appointment standards are collected and reviewed on a quarterly basis as part of the Quarterly Quality Management process, with corrective actions and sanctions imposed as appropriate.

6. To respond to 45 C.F.R. 96.126(e), each RBHA contract made it possible to fund and deliver outreach services for both Medicaid and SAPT funded members regardless of whether the individual subsequently enrolled in treatment. Drug abuse treatment agencies were practical in their use of outreach activities, since they knew there were insufficient resources to accommodate those who were drawn to treatment in the absence of focused outreach efforts. In Maricopa and Pima Counties, the HIV Early Intervention program has emerged as the primary outreach mechanism for IDU populations. Specific system outreach initiatives active in 2003 included a workshop on methadone treatment for criminal justice agencies, development of medication practice guidelines for seriously mentally ill opiate users, and new requirements for residential treatment programs to admit persons receiving methadone and other narcotic treatment medications.

Attachment D: Program Compliance Monitoring
(See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2004) to the fiscal year for which the State is applying for funds:

In up to three pages provide the following:

- A description of the strategies developed by the State for monitoring compliance with each of the sections identified below:
 1. Notification of Reaching Capacity 42 U.S.C. 300x-23(a)
(See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));
 2. Tuberculosis Services 42 U.S.C. 300x-24(a)
(See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(viii)); and
 3. Treatment Services for Pregnant Women 42 U.S.C. 300x-27(b)
(See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).
- A description of the problems identified and corrective actions taken.

RESPONSE:

1. 45CFR 96.126(f) and 45CFR 96.122(f)(3)(vii) Notification of Capacity

“Notification of Reaching Capacity” requirements were incorporated into the RBHA contracts for the time period under review in this attachment. The contract also includes requirements for interim service delivery and the 14/120-day admission standard. Requirements are also detailed in the ADHS/DBHS Provider Manual. There is no centralized computerized mechanism for capturing services to non-enrolled clients. Manual wait-lists are developed by each provider and submitted to the RBHA and the BSATP on a quarterly basis. RBHAs are selected for direct Bureau review based on problem resolution, service utilization and other data indicating excessive wait lists for IDU treatment. Beginning July 2003, all RBHAs were required in contract to review and analyze capacity information and trends identified in the wait lists as part of the annual Network Sufficiency and Development Plan deliverable. This requirement remained in place for FY 2004.

Both ValueOptions and CPSA implemented special performance improvement projects related to provision and coordination of methadone services during 2004-05. Wait list analysis instigated planning for expansion of both methadone and buprenorphine capacity and availability in Maricopa and Pima Counties as well as southeastern Arizona. (See Goals #1, #4 and #13 for greater detail) BSATP has provided

comment, recommendations and technical assistance in improving the wait list, including greater specification on acceptable forms of interim services (e.g., pre-treatment groups, referral to community social/welfare services, educational materials).

BSATP staff continued to monitor conversion rates for injection drug abusers to the TXIX-supported program to determine impacts on availability of funds to treat non-TXIX, high priority populations cited in the SAPT Block Grant. As of June 2004, more than 85% of IDU clients in Maricopa County were enrolled in the TXIX program. BSATP staff will work closely with the RBHAs to ensure appropriate use of funds, including possible expansion of engagement and outreach activities to non-TXIX supported, high priority IDUs. During 2004, one methadone agency in Maricopa County recruited peer worker staff to assist in improving engagement into treatment services.

2. 45C.F.R. 96.127(b) and 45C.F.R. 96.122(f)(3)(viii) Tuberculosis Services

The Department of Health Services funds all Counties and several Tribal governments for an array of tuberculosis screening and treatment services. Substance abuse treatment providers are aware of County services and make use of them through the referral process. Requirements to provide access to tuberculosis screening in residential environments are included in agency licensure standards and are monitored through the Office of Behavioral Health Licensure. These requirements are published in the current Administrative Rules for Behavioral Health Licensure (revised July 2002 and published July 2003), and all substance abuse treatment providers are required to acquire a license in order to operate in Arizona.

3. 45C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(viii) Treatment Services for Pregnant Women

Priority treatment has been offered to pregnant substance abusers by RBHA contracted providers for many years and is integrated into telephone and in-person screening processes at both the RBHA and provider level. In the most populated area of the State, Maricopa County, an intensive case management team for pregnant addicts has operated since the early 1990s and provides rapid assessment and placement in services within the 48-hour time frame. Similar teams and one-stop treatment sites were developed in Pima County and southeastern Arizona using SAPT funds during 2003-04.

During 2004, no pregnant women were placed on wait lists in Pima County, Yuma County, or Gila and Pinal Counties. Wait list and interim service data for pregnant women, and women with children, was directly reviewed on a quarterly basis for ValueOptions and NARBHA during SFY 2004. RBHAs are selected for direct Bureau review based on problem resolution, service utilization and other data indicating excessive wait lists for persons needing treatment.

The number of pregnant women who were wait-listed began to rise in Maricopa County in 2003 and continued in 2004. This change prompted the development of a new monitoring tool that will measure number of days from referral date to the date residential services began for each member, and whether timelines met required timeframes as prescribed by SAPT Block Grant requirements. It will also capture the number of days from referral date to the date interim services began, the number of

persons on a wait list, and the number of days from referral to first treatment service. Each agency providing services to this priority population will track the information captured monthly and submit it to the RBHA Substance Abuse Treatment coordinator who will transmit findings to DBHS quarterly. The transmittal will include a listing of residential treatment slots, a description of service gaps and plan to rectify those gaps. BSATP staff met quarterly with ValueOptions to review and discuss capacity issues and cross-agency referral practices that resulted in more women waiting for admission. These meetings led to new capacity for women added to the Maricopa county network including addition of two new nurse case managers for the pregnancy/addictions team and opening two new Level 2 residential substance abuse facilities for women with children during 2004.

NARBHA monitors the SAPT Block Grant populations on a monthly basis. NARBHA provides technical assistance to the contracted sub-area agencies, including agencies operating on tribal lands, who fall below compliance standards, as well as trainings to ensure the behavioral health providers are knowledgeable about the SAPT Block Grant requirements. NARBHA had not been tracking access to residential services and will be adding this to their tracking tool for 2006. NARBHA is the focus of an on-going substance abuse capacity assessment and monitoring process to ensure development of sufficient network services to treat pregnant women and other populations. BSATP staff is directly involved in a process that is on going and has requested CSAT TA to conduct a region-wide expert assessment of the NARBHA continuum for substance abuse treatment during 2006.

GOAL # 5.-- An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FY 2003 (COMPLIANCE):

OBJECTIVE: To make available, in each region of the State and as part of the regular admissions process, tuberculosis services.

ACTIVITIES:

- (1) By November 2003, review ADHS contracts to ensure inclusion of compliance language for tuberculosis services.
- (2) Through November 2003, participate in Annual Administrative Review audit process including requirements specific to provision of tuberculosis services, directly or through referral.
- (3) Review Office of Behavioral Health Licensure Administrative Rules to ensure inclusion of requirements related to physical exams and nursing services upon entry into residential services, including referral for TB services as appropriate.
- (4) Continue focus on communicable disease screening and referral, including tuberculosis, for new intensive case management teams for women in Pima County, southeastern Arizona and other areas of the state.

COMPLIANCE:

(1) **Contracts.** Contracts with the five Regional Behavioral Health Authorities were reviewed as part of the annual amendment process in the spring 2003. Specific language addressing requirements for tuberculosis screening and referral services is contained within the contracts. The DBHS also developed and released a new Provider Manual in September 2003. Requirement language for tuberculosis screening and referral services is detailed in this guide that is required for all behavioral health agencies contracted through the RBHA system. The Provider Manual includes both a general provider requirement and a specific requirement for pregnant women and injection drug abusers receiving interim services while on actively managed wait lists for treatment placement. The five-year administrative review period for Behavioral Health Licensing Rules ended June 30, 2003. BSATP staff reviewed rule changes to ensure continuation of requirements for physical exams/nursing assessments prior to admitting patients into residential care settings.

(2) **Audits/Performance Reviews.** The Annual Administrative Review was conducted in the fall of 2003. No corrective actions related to this standard were identified.

(3) **Quality Improvement/Network Expansion.** New intensive case management services were developed in Pima County and southeastern Arizona (MCAS program) during FY 2002 and 2003. The teams provide routine referrals for HIV and tuberculosis risk assessment, regardless of the enrollment status of the women. In northern Arizona, the regional behavioral health authority established an FTE position funded by the FY 2002 SAPT increase to establish coordination mechanisms with acute care health plans

for pregnant women and injection drug abusers. Tuberculosis referrals are one part of this effort. In Maricopa County, the Pregnancy and Addictions Team works closely with HIV services providers and the county public health department to ensure rapid referral, screening and support for tuberculosis and HIV services.

FY 2005 (PROGRESS):

OBJECTIVE: To make available, in each region of the State and as part of the regular admissions process, tuberculosis services.

ACTIVITIES:

- (1) Review ADHS/DBHS contracts with RBHAs to ensure inclusion of compliance language for tuberculosis services.
- (2) Continue focus on communicable disease screening and referral, including tuberculosis, for intensive case management teams for women.
- (3) Review data from ADHS notifiable disease database for HIV, hepatitis C and tuberculosis and identify any trends relevant to substance abuse services.

PROGRESS:

- (1) **Contracts.** Contracts with the five Regional Behavioral Health Authorities were reviewed as part of the annual amendment process in the spring 2004. Specific language addressing requirements for tuberculosis screening and referral services is contained within the contracts. The requirements were also embedded in the Request for Proposals for the Greater Arizona RBHA procurement released August 2004 as well as the ValueOptions contract for Maricopa County (effective July 2004).
- (2) **Provider Manual.** Implemented in September 2003, the Manual continues to serve as a single statewide template assuring consistency in all clinical requirements plus additional local information provided by each RBHA. A chapter, 'Special Populations,' includes SAPT requirements on tuberculosis screening and referral both as a general provider requirement and as a specific requirement for pregnant women and IDUs receiving interim services.
- (3) **Quality Improvement/Network Expansion.** Intensive case management teams for pregnant/parenting women continued to offer referrals for communicable disease screening, including tuberculosis, for enrolled women and well as women on wait lists for treatment. The BSATP began an effort to standardize wait list elements and definitions of interim services across the RBHAs to ensure greater consistency in reporting communicable disease and other services.

The BSATP reviewed notifiable disease reports for tuberculosis, hepatitis C and HIV/AIDS to identify any trends of significance for substance abuse service delivery. There were 263 cases of active tuberculosis reported in Arizona in 2002, 295 cases in 2003, and 272 cases in 2004. The majority of cases occurred in Maricopa County (68%) in 2004, followed by Pima County (7.7%) and Pinal County (9.1%). The increase in Arizona TB cases between 2002 and 2003 is attributed to an increase among two distinct groups; prisoners, primarily Immigration and Customs Enforcement (ICE) detainees (72% of AZ correctional cases in 2003) and children less than five years. The occurrence of TB in young children represents ongoing transmission in the community and is an

indicator of efficacy of TB program activities. Significantly, 77% of pediatric (<5 years) TB cases in 2003 occurred among Hispanics.

By comparison, 10,261 cases of hepatitis C were reported in 2002, 10,002 in 2003 and 11,063 in 2004. Although Maricopa County comprises 50% of all reported cases of non-acute hepatitis C, a broader array of counties report in excess of 450 cases, including Pima, Pinal, Yuma and Mohave.

(4) **Other Initiatives.** The BSATP continued to meet with the ADHS/Office of HIV Services in 2005 to ensure greater coordination and collaboration in resource distribution for communicable disease services. This effort includes a review of ADHS epidemiologic data and the state plan for HIV and communicable disease funding through U.S. Public Health Services/Centers for Disease Control. The meetings were expanded to include ADHS staff working in the areas of hepatitis C and tuberculosis. Based on the notifiable disease data, BSATP also sponsored a series of in-service trainings on hepatitis C during the spring and summer 2004.

FY 2006 (INTENDED USE):

OBJECTIVE: To make available, in each region of the State and as part of the regular admissions process, tuberculosis service

- (1) Review ADHS/DBHS contracts with RBHAs to ensure inclusion of compliance language for tuberculosis services.
- (2) Complete review and standardization of wait list reporting elements including referrals for communicable disease screening and services.
- (3) Review data from ADHS notifiable disease database for HIV, hepatitis C and tuberculosis, identify any trends relevant to substance abuse services and develop a plan of action.

GOAL # 6.-- An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).

FY 2003 (COMPLIANCE):

OBJECTIVE: To ensure availability of early intervention services for HIV in areas of the state with the greatest need and to monitor delivery of services.

ACTIVITIES:

- (1) ADHS/DBHS will ensure appropriate fiscal and budget controls for expenditure of the 5% HIV set-aside in years when Arizona is a designated state.
- (2) ADHS/DBHS will identify and select the most appropriate area(s).
- (3) ADHS/DBHS will incorporate monitoring responsibilities for such services into the sub-state authority contract.
- (4) ADHS/DBHS will continue to monitor the development and provision of HIV Early Intervention through focused technical assistance, updates to the state guidelines, training on new CDC protocols for service delivery to special populations including pregnant women and IDUs, and conversion to the OraQuick® Rapid HIV-1 Antibody Test.

COMPLIANCE:

- (1) **Contracts.** In FY 2003 Arizona became a designated state again for the purposes of the HIV Early Intervention requirement. Funds were isolated in the allocation schedule for SFY 2004 from the 2003 Block Grant award, following Arizona's traditional practice. A Memorandum of Understanding remained in place with the Arizona State Laboratory and with the Office of HIV/AIDS for provision of OraSure testing and specimen processing services. The Office of HIV/AIDS Memorandum was augmented to incorporate OraQuick® Rapid HIV-1 Antibody testing in Maricopa County. The areas of greatest need remained the two metropolitan counties, Pima and Maricopa and northern Arizona, however BSATP elected to continue program services through all RBHAs contracts during this period.

Vendor contracts were reviewed during the annual amendment process in the spring of 2003 to ensure continued inclusion of appropriate language addressing financial and programmatic requirements for HIV services. More specific language was drafted for the new ADHS/DBHS Provider Manual detailing the responsibilities of providers delivering HIV Early Intervention Services. The new Provider Manual, published in September 2003, serves as a template for all agencies contracting in the RBHA system to ensure consistency in communication of clinical and financial requirements.

- (2) **Audits/Performance Reviews.** Effective July 1, 2002, ADHS/DBHS procedure (encounter) code based reporting of HIV services was discontinued. ValueOptions and CPSA were authorized to develop block purchases or other appropriate contracting

mechanisms to ensure continued delivery of the set of HIV services. The BSATP undertook an on-site review and re-design of reporting processes for the HIV programs in Maricopa and Pima Counties, culminating in development of a special quarterly report to track client services and performance measures implemented in January 2003. The BSATP also initiated a quarterly review of expenditure levels for the set-aside program using unaudited and year-end audited RBHA financial reports.

For January to June 2003, COPE Insiders (Pima County) served 163 persons at the site where they receive treatment, 500 persons through the drop-in center and 450 persons in other community settings. Services delivered at the treatment site included: 124 HIV risk assessments, 1,619 units of health promotion/education, 82 pre-test counseling sessions, 64 post-test counseling sessions and 82 HIV tests.

For April to June 2003, Terros (Maricopa County) served 481 persons at the site where they receive treatment and 539 persons through the drop-in center. Services delivered at the treatment site included: 481 HIV risk assessments, 481 pre-test counseling sessions, 227 post-test counseling sessions, 472 HIV tests and 3 HIV case management services.

(3) **Quality Improvement/Network Expansion.** The BSATP and ValueOptions worked with Terros in Maricopa County to convert the majority of HIV testing to the OraQuick® Rapid Test. Conversion was completed in the winter 2004.

All existing HIV services sites were maintained during FFY 2003. In the two urban counties, the HIV Early Intervention program provides services in four venues: (a) **Priority 1 services** are delivered at the site where individuals receive their substance abuse treatment, including residential and methadone facilities and pregnancy/addictions case management team sites; (b) **Priority 2 services** are delivered at outpatient clinic sites for persons with serious mental illness and co-occurring substance use disorders who exhibit high HIV risk behavior; (c) **Priority 3 services** are delivered through street outreach/drop-in centers serving homeless individuals, injection drug abusers and women on wait lists for treatment, including a large number of transgender persons; and (d) **Priority 4 services** are delivered in other community settings at high risk for substance abuse and HIV as part of pre-treatment engagement services. These sites include probation offices, domestic violence facilities and homeless shelters. (See Attachment E for sites and linkages)

FY 2005 (PROGRESS):

OBJECTIVE: To ensure availability of early intervention services for HIV in areas of the state with the greatest need and to monitor delivery of services.

ACTIVITIES:

- (1) ADHS/DBHS will ensure appropriate fiscal and budget controls for expenditure of the 5% HIV set-aside in years when Arizona is a designated state.
- (2) ADHS/DBHS will identify and select the most appropriate area(s).
- (3) ADHS/DBHS will incorporate monitoring responsibilities for such services into the sub-state authority contract.

(4) ADHS/DBHS will continue to monitor the development and provision of HIV Early Intervention Services through focused technical assistance, updates to the state guidelines, training on new CDC protocols for service delivery to special populations including pregnant women and IDUs, and expanding conversion to the OraQuick® Rapid HIV-1 Antibody Test.

PROGRESS:

(1) **Expenditures/Funding.** Arizona was a designated state for the HIV Early Intervention set-aside in FFY 2005. Arizona's traditional practice is to obligate and expend the HIV set-aside in one state fiscal year. Thus, set-aside funds derived from the 2004 SAPT award were expended in SFY 2005 and the set-aside from the 2005 SAPT award will be expended in SFY 2006. Funds were isolated in the allocation schedule during the spring 2004 budget review process. The Memorandum of Understanding with ADHS State Laboratory and ADHS Office of HIV/AIDS Services was continued in 2005. The agreements provide centralized bulk purchasing, distribution and specimen sampling for OraSure to agencies funded to conduct HIV Early Intervention Services throughout the state. In addition, the BSATP met with the ADHS Office of HIV Services in 2004 to discuss the CDC-funded HIV program and to compare regional and target population distributions of HIV testing funds from the SAPT Block Grant and the Centers for Disease Control. This information was used to determine the rural region HIV set-aside allocations for SFY 2005.

(2) **Contracts/Policy.** RBHA contracts were renegotiated during the spring 2004 annual amendment process to ensure inclusion of appropriate language addressing financial and programmatic requirements for HIV services. For SFY 2004, the Gila River Indian Community TBHA was added as a recipient of SAPT Block Grant funds, including HIV set-aside funds. Contractual and Provider Manual language detailing requirements of the HIV program remained in place and were also incorporated into the Request for Proposals for the Greater Arizona RBHA procurement conducted in the spring 2005.

(3) **Quality Improvement/Network Expansion.** The BSAPT partnered with ADHS Office of HIV/AIDS Services to expand purchasing of OraQuick ® Rapid HIV-1 Antibody test kits in Maricopa and Pima Counties. The Rapid Test implementation began in January 2004 and continued through successive rollouts to different provider sites through 2005. The increased use of Rapid Tests led to significant improvements in the number of individuals receiving post-test counseling, treatment engagement services and case management services.

In the spring of 2005 a meeting was held with the Gila River TRBHA to discuss the implementation of their HIV Program and the problems they were encountering in delivering the service on the reservation. The Gila River TRBHA subsequently contracted with a 638 program staff hired by the tribe to deliver HIV services in the community and used this staff to provide testing and education services to TRBHA enrolled members.

The Greater Arizona RFP for the RBHAs in the balance of the State was negotiated and completed, effective July 2005 and resulted in two of the RBHAs

(PGBHA and EXCEL) losing their ADHS contract. In the summer of 2005, a meeting was held with Cenpatco of Arizona, the new RBHA for these two regions, detailing the HIV Early Intervention program and process, including reporting requirements and program methodologies. The BSATP also held meetings with Maricopa and Pima County HIV Early Intervention providers in the summer 2005 and reviewed data from their quarterly reports, including trends in treatment site coverage and delivery of specific services. Information from these meetings will be used to standardize the data definitions and to increase monitoring of the RBHAs' HIV Early Intervention programs. ADHS/DBHS will begin expanding the quarterly report statewide in the fall 2005.

(4) Provider Network and Services Delivered.

The HIV Early Intervention program provides services in four venues: (a) **Priority 1 services** are delivered at the site where individuals receive their substance abuse treatment, including residential and methadone facilities and pregnancy/addictions case management team sites; (b) **Priority 2 services** are delivered at outpatient clinic sites for persons with serious mental illness and co-occurring substance use disorders who exhibit high HIV risk behavior; (c) **Priority 3 services** are delivered through street outreach/drop-in centers serving homeless individuals, injection drug abusers and women on wait lists for treatment, including a large number of transgender persons; and (d) **Priority 4 services** are delivered in other community settings at high risk for substance abuse and HIV as part of pre-treatment engagement services. These sites include probation offices, domestic violence facilities and homeless shelters.

In Maricopa County, the HIV Early Intervention program is contracted to a single specialized provider serving all substance abuse and SMI clinic sites. The Terros Together program is a licensed outpatient satellite clinic and HIV drop-in center in central Phoenix. The program provides both mobile and drop-in HIV risk assessment, pre/post counseling and testing, as well as education and engagement into treatment. Case management, psychiatric appointments and coordination of housing services for HIV positive clients are offered through a Terros subcontractor (Phoenix Shanti).

In Pima County, the HIV Early Intervention program is also contracted to a single, specialized provider serving all substance abuse treatment and SMI clinics in metropolitan Tucson. The COPE Insiders program is a licensed outpatient clinic and HIV drop-in center in central Tucson that is co-located with an auricular acupuncture facility. In 2005, the Pima County RBHA funded Cope Insiders to pilot an integrated (physical and behavioral health) program to expedite access to the RBHA's services through a subcontract with El Rio Special Immunology Associates, which is Southern Arizona's largest HIV health care clinic.

In northern Arizona, required services are delivered through subcontracts with local county public health departments, which deliver on-site HIV assessment, education and testing at residential, and outpatient substance abuse agencies in Flagstaff, Kingman and Prescott.

In southeastern Arizona, required services are delivered through a single outpatient behavioral health contractor serving all agency sites in four counties. Services include HIV risk assessment, education and referrals for testing. The RBHA is also developing an agreement to work with the Cochise County Health Department to plan

and implement targeted interventions in high- risk neighborhoods or to specific populations such as pregnant women and teens.

The Gila River Indian Community provides HIV services to enrolled members and coordinates referrals for on-going services with the tribal 638 program. The Gila River Indian Community also hired a person to provide HIV services to tribal members returning to the reservation and meet with the Tribal Health Department to coordinate services.

For SFY 2005, the following services were delivered:

Terros Together (Maricopa County)

Terros served 4,196 enrolled clients at treatment sites, 1,794 pre-treatment and homeless persons at the Phoenix drop-in center and 589 persons in other community settings. Services delivered at the treatment site (units of service): 1,131 risk assessments, 19,389 educational units, 1,041 pre-test counseling services, 871 post-test counseling services, 1,028 HIV tests. The number of individuals receiving post-test counseling rose by 34% in 2005 vs. 2004 due to the implementation of Rapid Test.

COPE Insiders (Pima County)

COPE Insiders served 1,892 enrolled clients at treatment sites, 807 pre-treatment and homeless persons at the Tucson drop-in center and 754 persons in other community settings. Services delivered at the treatment site (units of service): 142 risk assessments, 6,672 educational units, 291 pre-test counseling services, 245 post-test counseling services, 163 HIV tests. The number of individuals receiving post-test counseling rose by 16% in 2005 vs. 2004 due to the implementation of Rapid Test.

FY 2006 (Intended Use):

OBJECTIVE: To ensure availability of early intervention services for HIV in areas of the state with the greatest need and to monitor delivery of services.

ACTIVITIES:

- (1) ADHS/DBHS will ensure appropriate fiscal and budget controls for expenditure of the 5% HIV set-aside in years when Arizona is a designated state.
- (2) ADHS/DBHS will identify and select the most appropriate area(s).
- (3) ADHS/DBHS will incorporate monitoring responsibilities for such services into the sub-state authority contract.
- (4) ADHS/DBHS will continue to monitor the development and provision of HIV Early Intervention Services through focused technical assistance, updates to the state guidelines, training on new CDC protocols for service delivery to special populations including pregnant women and IDUs, and continued provision of the OraQuick® Rapid HIV-1 Antibody Test where possible.

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
(See 45 C.F.R. 96.122(f)(1)(x))

For the fiscal year three years prior (FY 2003) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a "designated State," provide funds expended (or obligated), for early intervention services for HIV.

Examples of **procedures** include, but are not limited to:

- development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);
- the role of the single State authority (SSA) for substance abuse prevention and treatment; and
- the role of the single State authority for public health and communicable diseases.

Examples of **activities** include, but are not limited to:

- the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
- the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;
- the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and
- technical assistance.

TB Services

Procedures

The Department of Health Services funds all Counties and several Tribal governments for an array of tuberculosis screening and treatment services. Substance abuse treatment providers are aware of County services and make use of them through the referral process. Requirements to provide access to tuberculosis screening in residential environments are included in agency licensure standards and are monitored through the Office of Behavioral Health Licensure. These requirements are published in the current Administrative Rules for Behavioral Health Licensure.

Activities

1. Activities with the five RBHAs were reviewed as part of the annual amendment

process in the spring 2003. Specific language addressing requirements for tuberculosis screening and referral services is contained within the contracts.

2. The five-year administrative review period for Behavioral Health Licensing Rules ended June 30, 2003. BSATP staff reviewed rule changes to ensure the continuation of requirements for physical exams/nursing assessments prior to admitting patients into residential care settings.
3. Tuberculosis screening was also addressed in the new ADHS/DBHS Provider Manual, published in September 2003. The Manual addresses both general provider requirements and specific requirements for pregnant and injection drug abusers receiving interim services while on actively managed wait lists for treatment placement. The Provider Manual serves as a template for all agencies contracting in the RBHA system to ensure consistency in communication of financial, clinical and program requirements.
4. New intensive case management services were developed in Pima County and southeastern Arizona (MCAS program) during 2002 and 2003. The teams provide routine referrals for HIV and tuberculosis risk assessment, regardless of the enrollment status of the women. In northern Arizona, the RBHA established an FTE position funded by the Block Grant award that established coordination mechanisms with acute care health plans for pregnant women and injection drug abusers. Tuberculosis referrals are one part of this effort. In Maricopa County, the Pregnancy and Addictions Team works closely with HIV services providers and the county public health department to ensure rapid referral, screening and support for tuberculosis and HIV services.

HIV Early Intervention Services

Procedures

Arizona was a designated state for the HIV Early Intervention set-aside in FY 2003. In SFY 2003, \$1,356,657 was spent from the 2002 Block Grant on HIV/AIDS services. The FY 2003 HIV set aside of \$1,527,437 was expended in SFY 2004.

The role of the SSA has focused on establishing, monitoring and expanding appropriate delivery of HIV Early Intervention Services through behavioral health agencies contracted in the RBHA system. Specific areas of SAA leadership in SFY 2003 included conducting an independent assessment of the use of HIV procedure codes (encounters) as the method of ensuring appropriate service delivery and efficient use of funds, establishing a new block purchase and quarterly report method for accountability, and renegotiating the Memorandum of Understanding with the Arizona State Lab and the Office of HIV Services. The BSATP and the ADHS Office of HIV Services also conducted joint trainings of Grant-funded HIV providers on implementation of Rapid Test with an initial rollout in the fall 2003.

The role of the Office of HIV Services, within the Public Health Division of the Department of Health Services, is to manage Ryan White and other funds for HIV service programming through the county public health agencies. To ensure more effective coordination of limited funds for substance abuse treatment and HIV service delivery, the BSATP continued its Memorandum of Understanding (MOU) with the HIV Office to support a system for providing bulk OraSure kits to HIV Early Intervention programs and

to support the conversion to Rapid Test. Under this MOU, the Office of HIV purchases bulk quantities of test kits and distributes these to RBHA contracted providers offering the HIV service. The ADHS State Laboratory conducts free processing of OraSure samples through a second MOU instrument. The agencies have continued the purchasing arrangement in subsequent years and have begun discussions to create a more effective way to track numbers of OraSure kits provided and samples processed from behavioral health agencies. Beginning in the fall 2004, the BSATP began providing OraQuick® Rapid HIV-1 Antibody Test kits purchased through the Office of HIV Services.

Activities

During 2001-02, the BSATP utilized an independent contractor to review procedure code utilization for HIV services. This effort resulted in a re-design of the reporting process for this service which eliminated encounter based reporting and transitioned contractors to a block purchase arrangement effective July 2002. BSATP also conducted an on-site review of the two major HIV provider agencies as part of the re-design project in the summer 2002. Effective for SFY 2003, DBHS implemented a new quarterly report process that captures units, performance measures and unduplicated consumers served for HIV services.

BSATP staff also began reviewing the new CDC protocols for HIV in high-risk populations (co-occurring, IDU and pregnant substance abusing women) and made these available to community agencies. BSATP has provided technical assistance to improve HIV and TB service delivery associated with the 'interim services' process.

In September 2003 to January 2004, the BSATP and the Office of HIV Services conducted joint trainings of Grant-funded HIV providers on implementation of the Rapid Test. BSATP staff have also provided direct technical assistance regarding submission of performance data from HIV delivery sites (2003, 2004).

Sites and Linkages

ValueOptions

In Maricopa County, the HIV Early Intervention program was contracted to a single specialized provider serving all substance abuse and SMI clinic sites. The Terros Together program is a licensed outpatient satellite clinic and HIV drop-in center in central Phoenix. The program provides both mobile and drop-in HIV risk assessment, pre/post counseling and testing, as well as education and engagement into treatment. Case management, psychiatric appointments and coordination of housing services for HIV positive clients are offered through a Terros subcontractor (Phoenix Shanti).

Community Partnership of Southern Arizona

In Pima County, the HIV Early Intervention program was also contracted to a single, specialized provider serving all substance abuse treatment and SMI clinics in metropolitan Tucson. The COPE Insiders program is a licensed outpatient clinic and HIV drop-in center in central Tucson that is co-located with an auricular acupuncture facility.

In southeastern Arizona, required services were delivered through a single outpatient behavioral health contractor serving all agencies' sites in four counties. Services include HIV risk assessment, education and referrals for testing.

Northern Arizona Behavioral Health Authority

In northern Arizona, required services were delivered through subcontracts with local county public health departments that deliver on-site HIV assessment, education and testing at residential and outpatient substance abuse agencies in Flagstaff, Kingman and Prescott.

The EXCEL Group

THE EXCEL Group negotiated an agreement with Yuma County Public Health to provide free testing to EXCEL's clients.

Pinal Gila Behavioral Health

PGBHA, serving Pinal and Gila Counties, funded one program (Horizon Human Services). Horizon Human Services is located in the Casa Grande and Globe areas. Each location coordinates with its respective County Public Health agency for HIV testing and counseling.

GOAL 7:

An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25 and 45 CFR 96.129).

FFY 2003 (COMPLIANCE):

Participation in the Oxford House program was made optional by the Children's Health Act of 2000. ADHS/DBHS did not operate a revolving loan program under the SAPT grant in FY 2002.

FFY 2004 (PROGRESS):

ADHS/DBHS did not operate a revolving loan program under the SAPT grant in FY 2004.

FFY 2005 (INTENDED USE):

ADHS/DBHS does not intend to operate a revolving loan program under the SAPT grant.

Attachment F: Group Home Entities and Programs

(See 42 U.S.C. 300x-25; 45 C.F.R. 96.129; and 45 C.F.R. 96,122(f)(1)(vii))

If the state has chosen in Fiscal Year 2003 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund then attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2003 to establish group homes for recovering substance abusers. In a narrative of up to two pages, describe the following:

- the number and amount of loans made available during the applicable fiscal years;
- the amount available in the fund throughout the fiscal year;
- the source of funds used to establish and maintain the revolving fund;
- the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;
- the private, nonprofit entity selected to manage the fund;
- any written agreement that may exist between the State and the managing entity;
- how the State monitors fund and loan operations; and
- any changes from previous years operations.

RESPONSE:

Not applicable.

GOAL # 8.--An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26 and 45 C.F.R. 96.130).

- . Is the State's Synar report included with the FY 2006 uniform application?
☒ Yes ☐ No
- . If No, please indicate when the State plans to submit the report: mm/dd/2006

GOAL # 9.-- An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).

FY 2003 (COMPLIANCE):

OBJECTIVE: Ensure development, improvement, monitoring and maintenance of preferential access standards for pregnant women, including provision of interim services to pregnant substance abusers that must wait for appropriate substance abuse treatment.

ACTIVITIES:

- (1) Review ADHS/DBHS contracts and policy to ensure inclusion of compliance language for preferential access to care and provision of interim services.
- (2) Monitor RBHA compliance with preferential access standards, including review of data reporting mechanisms, wait lists and corrective action as appropriate.
- (3) Review random selection of RBHA contracts with providers, member handbooks and marketing materials to ensure inclusion of compliance language for preferential access to substance abuse treatment for pregnant women.
- (4) Continue BSATP participation in the SB 1280 Joint Fund implementation and monitoring, including technical assistance to SB 1280 contractors on the AHCCCS eligibility process and ensured provision of interim treatment while the eligibility process is completed.

COMPLIANCE:

(1) Contracts/Policy. Language continued in the SFY 2003 RBHA contracts that requires priority placement for pregnant women and management of local wait list processes. Requirements were also added to the ADHS/DBHS Provider Manual published in September 2003. The Provider Manual serves as a standardized template for communicating all state requirements to the provider level. Requirements on provision of interim services was also continued and reviewed by the BSATP during the 2003 amendment process. Member handbooks are also subject to annual ADHS/DBHS review and approval. As of January 2003, all handbooks contained language indicating that pregnant women have priority access to services.

(2) Audits/Performance Reviews. The BSATP continued to review wait list data for each RBHA based on those regions experiencing difficulties in achieving the timeframes for preferential access. During 2003, BSATP required quarterly wait list submission for ValueOptions and NARBHA. All other RBHAs submit data annually as part of the RBHA Network Development and Sufficiency Plan. During 2003, the total number of women on wait lists for treatment began to grow in Maricopa County, although pregnant women were still accommodated within the 48-hour timeframe. BSATP worked through the DBHS Network Development Teams and annual Network Sufficiency Report process

(e.g. Logic Model) to identify capacity issues that could slow the admissions flow for pregnant women.

(3) Quality Improvement/Network Expansion. The BSATP worked collaboratively with ValueOptions, CPSA and NARBHA during 2003 to ensure preferential access standards were upheld and achieved despite enormous growth in the number of women enrolled through the Medicaid expansion. These efforts included management of Performance Improvement Plans submitted by each RBHA in the summer of 2001 that resulted in specific capacity studies and improvement activities. Measures undertaken through the plans included establishment of direct contracts between SAPT Block Grant funded women's programs and TXIX provider networks in Pima county, and development of a countywide consortium of service providers to address the needs of pregnant, substance-using women. Also, in NARBHA's Region, a systematic review of access to care standards for pregnant/parenting women was completed.

In Maricopa county, BSATP worked closely with ValueOptions and the substance abuse provider network during FFY 2003 on specific strategic plan goals to improve access to care for pregnant women. Initiatives included ongoing meetings of the specialty women's providers, training of crisis line, service authorization line and RBHA/provider customer service staff to ensure awareness of preferential access requirements. In addition, BSATP staff developed written guidelines for coordination of services between RBHA services and programs contracted through Arizona Families FIRST to ensure rapid placement of women and families undergoing the TXIX eligibility process. Finally, BSATP staff continued to monitor conversion rates for substance abusing women to the TXIX program to determine impacts on demand for services that may result in more extensive wait lists.

New funds available through the FFY 2003 SAPT increase were also used to reduce wait lists and improve access to care, including: (1) establishing intensive case management teams for women who are pregnant or have young children (CPSA,; (2) adding new staff and vans to the ValueOptions Pregnancy and Addictions Case Management Team; and establishing network development goals for adding women's treatment residential capacity in Maricopa county. (See Goal 3 for greater detail)

(4) Other Initiatives. The BSATP continued to identify opportunities for expanded training on services for women. During the 2003 Summer Substance Abuse Institute in partnership with the Substance Abuse Coordinators from ValueOptions and CPSA, the BSATP chief provided a special workshop on gender-specific substance abuse treatment.

The BSATP continued to participate in the implementation of SB 1280 Joint Substance Abuse Treatment Fund during SFY 2003. This project provides expedited access to family centered substance abuse treatment for parents involved in the child welfare system. During SFY 2003, the BSATP assisted in the development of local protocols to coordinate assessments and service delivery between SB 1280 and TXIX contractors to ensure access to care for pregnant and parenting women.

FY 2005 (PROGRESS):

OBJECTIVE: Ensure development, improvement, monitoring and maintenance of preferential access standards for pregnant women, including provision of interim services to pregnant substance abusers who must wait for appropriate substance abuse treatment.

ACTIVITIES:

- (1) Review ADHS/DBHS contracts and policy to ensure inclusion of compliance language for preferential access to care and provision of interim services.
- (2) Monitor RBHA compliance with preferential access standards, including review of data reporting mechanisms and corrective action as appropriate.

PROGRESS:

- (1) **Contract/Policy.** Language continued in the SFY 2005 RBHA contracts that requires priority placement for pregnant women and management of local wait lists processes. Requirements on provision of interim services was also continued and reviewed by the BSATP. DBHS also continued use of the new Provider Manual. The Provider Manual serves as a single statewide template for all clinical requirements to ensure consistency among geographic areas and RBHA contractors. Each RBHA added specific, local implementation information to the template based on its unique network and contracting procedures. The Provider Manual contains a specific chapter on Special Populations, which includes SAPT requirements on priority populations, including specialized services for pregnant women and women with dependent children. In the spring 2004, BSATP staff reviewed each RBHAs Manual including customized language relevant to each Region, to ensure consistency and compliance with SAPT requirements.
- (2) **Quality Improvement/Network Expansion.** During 2003-04, the BSATP formalized the position of the Women's Treatment Coordinator within the bureau. This position is intended to be the single point of contact for technical assistance for women's programming. The Coordinator reviews wait list data and timeframes for admission for pregnant women and provides feedback to RBHAs as indicated. During 2005, the Coordinator refined the current wait list tool and procedures to ensure greater consistency across the state. Wait list data was made a specific element of the Arizona Network Logic Model during 2003-04 to ensure that information on demand and needed capacity for pregnant women was considered in development of network expansion goals. (See Goal 3 for greater detail)

FY 2006 (INTENDED USE):

OBJECTIVE: Ensure development, improvement, monitoring and maintenance of preferential access standards for pregnant women, including provision of interim services to pregnant substance abusers who must wait for appropriate substance abuse treatment.

ACTIVITIES :

- (1) Review ADHS/DBHS contracts and policy to ensure inclusion of compliance language for preferential access to care and provision of interim services.
- (2) Monitor RBHA compliance with preferential access standards, including review of data reporting mechanisms and corrective action as appropriate.

Attachment G: Capacity Management and Waiting List Systems (See 45 C.F.R. 96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2004) to the fiscal year for which the State is applying for funds:

In up to five pages provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c) respectively). This report should include information regarding the utilization of these systems.

Examples of **procedures** may include, but not be limited to:

- Development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;
- The role of the Single State Authority (SSA) for substance abuse prevention and treatment;
- The role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and
- The use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of **activities** may include, but not be limited to:

- How interim services are made available to individuals awaiting admission to treatment;
- The mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment;
- Technical assistance

Procedures

For FY 2004, the RBHAs were responsible for capacity management and waiting list maintenance. These requirements are largely manual lists collected by provider agencies that include unique client identification numbers, dates of referral and placements and interim services delivered in lieu of placement within timeframes. Wait list requirements are detailed in the following documents: RBHA Contract, DBHS Provider Manual. Each RBHA has developed specific policies, subject to BSATP review and approval, and provider training addressing wait list and capacity management for pregnant clients and injection drug users. RBHAs identified as needing technical assistance in ensuring immediate access to care for pregnant clients are required to submit wait list data to the BSATP on a quarterly basis. Others incorporate an analysis of the data, including implications for network expansion, on an annual basis through the annual provider network status report.

The role of the SSA (Single State Authority) in wait list management is to establish and enforce standards for tracking individuals on wait lists and to provide technical assistance to RBHAs in utilizing the data to understand capacity and demand

within their networks. The role of the RBHA is to collect, audit and analyze wait list data from provider agencies and to identify areas for improvement (e.g., additional capacity to be added, as funds are available, or improved cross-referral mechanisms for reducing wait lists).

Monthly Priority Admissions reports are received by the RBHAs from all providers in their system that receive SAPT Block Grant funding. Reports are reviewed when submitted and notations are made where timelines for priority populations are not being met. Providers are contacted whenever guidelines have not been met to initiate corrective action. When required, quarterly summary reports are submitted to the BSATP for analysis so that trends can be clearly noted over the course of the year.

For 2005, BSATP intends to refine and standardize the wait list tool and procedures to ensure greater uniformity of data collection across the state.

Activities

Cross-referral among RBHAs is practical and has been used informally over time. RBHA CEOs, in conjunction with ADHS/DBHS, developed specific policies and guidelines for inter-RBHA referrals (completed in Spring 1999) as well as standardized definitions for interim services within a region. These policies were transitioned to the required RBHA Provider Manual when DBHS published its template document in September 2004. Specific wait list requirements contained in the RBHA contract have been audited by BSATP through the annual Administrative Review since 1998. It is not possible to determine the amount of funds that may have been spent on capacity management or waiting list maintenance as these are not direct service activities and must be supported through administrative program funds.

The RBHAs were trained on the Network Logic Model during SFY 2003 and 2004. The model has been used by ADHS/DBHS Network Teams since 2001. This model utilizes data and trending information from multiple data sources (including case management utilization, network inventory, service utilization, problem resolutions, grievance and appeals, performance measures, enrollment data, member satisfaction results, demographics, provider network listing, independent case review results and cultural needs), to determine the adequacy of the network. Wait list data was added as a specific component of the Logic Model analysis during 2003 and has been used to support expansion of treatment services for women (See Goal 3 for greater detail). The Logic Model is used to establish capacity expansion targets and plans each year.

GOAL # 10.-- An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FY 2003 COMPLIANCE:

OBJECTIVE: Implement standardized statewide assessment, level of care criteria and service authorization standards.

ACTIVITIES:

(1) Beginning October 2002, participate in DBHS Strategic Objective Implementation Teams focusing on implementation of a standardized assessment, level of care criteria and service authorization guidelines for statewide use.

OBJECTIVE: Continue initiatives to improve engagement and retention in treatment services.

ACTIVITIES:

(1) Beginning October 2002, continue participation in the CSAT-funded Practice Improvement Collaborative (formerly Practice-Research Consortia), including the fourth annual Summer Institute, to identify and implement evidence-based treatment approaches.

(2) Implement findings of the DBHS Strategic Objective Implementation Teams on level of care and service authorization to improve client engagement and retention.

(3) Continue extensive cross-collaboration with Child Welfare System to foster family-centered treatment among adults with children in foster care.

OBJECTIVE: Implement outcomes monitoring system for the Performance Partnership Block Grant.

ACTIVITIES:

(1) Beginning October 2002, participated in DBHS Strategic Objective Implementation Team on data system re-design and outcome measurement.

COMPLIANCE:

(1) **Contracts.** Multi-disciplinary teams were established across the Division to implement strategic objectives associated with improving the assessment process, clarifying service authorization standards and refining the data system for outcome measurement. Upon completion, all new requirements will become mandatory for providers contracted in the RBHA system.

(2) **Quality Improvement.**

- **Assessment.** A team of DBHS staff, including Bureau Chiefs and the two Medical Directors, convened in July 2002 to identify areas for improvement in the behavioral health assessment process. An initial set of recommendations was released in November, which focused on paperwork reduction activities and action steps to

reduce the time necessary to complete an assessment while ensuring a high-quality process. The internal team recommended the establishment of a standardized core behavioral health assessment for use with all populations and age groups seeking behavioral health services. Beginning in January 2003, a statewide stakeholder group was formed to assist in defining elements, items and components of the core assessment. The BSATP convened a second work group to finalize content of a standardized substance abuse screen and assessment that emphasized differential diagnosis for substance use, abuse and dependence. After two rounds of pilot tests involving more than 100 clients in four RBHAs, a final assessment document was produced to be put into practice January 1, 2004. The tool contains a mandatory substance abuse screen and a standardized substance abuse assessment for persons whose response on the screening portion “triggers” the need for additional detail. Statewide training on the new assessment tool was developed and conducted throughout the fall 2003. An overview provided at the Summer Substance Abuse Institute in Sedona in the summer 2003 was attended by more than 150 clinicians.

- **Credentialing and Privileging.** The BSATP served as lead for the credentialing and privileging strategic objective, focused on establishing consolidated standards for behavioral health professionals. A small work group examined state licensing, state statute and standards for accreditation as these apply to professional practice standards and competence. Products of the work group included standardization of language on credentialing and privileging in the RBHA contracts, release of the DBHS Policy on Credentialing, and establishment of a DBHS credentialing and privileging process for professionals who will conduct the behavioral health assessment or serve as clinician liaison. The new standards reduced minimum credentials to the level of Associate of the Arts degree to allow for greater workforce flexibility and recruitment of diverse populations to provide assessment services. Clinicians credentialed at the AA or above level must also complete an ADHS/DBHS standardized training on assessment and assigned clinician in order to meet the new privileging standard.
- **Service Authorization.** An internal DBHS work group chaired by the Medical Director was established to review current policies and practices with regard to service authorization and medical necessity. The final recommendation of the group was to adhere to existing Level 1 authorization and continuing stay standards as required by 45 CFR and eliminate all other prior authorization requirements. Thus, only inpatient and free-standing residential psychiatric and detoxification services require prior authorization and no authorization is allowed for services needed on an emergency basis. RBHAs may request to prior authorize certain services and settings but must be approved by the Medical Director. A new DBHS policy on Medical Necessity and Prior Authorization was released with extensive training and RBHA follow-up through the spring of 2003.
- **Data System Re-Design.** An internal DBHS work group including the BSATP Chief convened in December 2002 to begin a re-design process for the client information data system. Specifications and data definitions of the new system were structured

around producing necessary outcome measures for SAPT and CMHS Block Grant reporting, as well as other required outcome reports. The new data file went live August 8, 2003. Training in the refined submission process and data elements began in September.

- **Child Welfare.** Arizona Families F.I.R.S.T. is a statewide program for substance abusing families whose children are entering the child welfare system as well as substance abusing families receiving cash assistance through Temporary Assistance for Needy Families (TANF). Both the Department of Economic Security and the Department of Health Services collaborated in implementing this program. An evaluation process was established to focus on nine geographic sites for implementation of the Arizona Families F.I.R.S.T. substance abuse prevention and treatment program, including referral procedures for families eligible under the ADHS Medicaid program. Examined were factors contributing to success such as timeliness, availability and accessibility of services, recovery from alcohol and drug problems, child safety, stability for the child through reunification, and the achievement of self-sufficiency by the family through employment.

FY2005 PROGRESS

OBJECTIVE: Continue to enhance the statewide assessment process to ensure individuals are referred to and receive the most appropriate services.

ACTIVITIES:

- (1) Participate on the ADHS/DBHS internal Assessment Work Group to review and refine the tool and process.
- (2) Provide training and technical assistance to RBHAs and provider organizations, as requested.
- (3) Assist other state agencies and systems in coordinating referral and assessment practices to ensure seamless care for persons seeking behavioral health services.
- (4) Continue implementation of the ADHS/DBHS Cultural Competency Plan and participation on the Behavioral Health/Higher Education Partnership to expand the availability of qualified professionals to deliver behavioral health services.

OBJECTIVE: Continue initiatives to improve engagement and retention in treatment services.

ACTIVITIES:

- (1) Implement the clinical team structure for substance abuse services.
- (2) Support and expand the use of Peer/Family Support services in substance abuse settings to improve engagement and retention in treatment.
- (3) Decrease stigma of behavioral health services, through DBHS efforts and a public awareness campaign.

OBJECTIVE: Implement outcomes monitoring system for the Performance Partnership Block Grant.

ACTIVITIES:

- (1) Develop standardized data extraction protocols for National Outcome Measures and design a communication/report-card strategy.

PROGRESS:

- (1) **Contracts/Policy.** The new Core Assessment and Team Process were established in vendor contracts effective July 2004.

- (2) **Quality Improvement/Network Expansion.** The ADHS/DBHS internal Assessment Work Group convenes on a quarterly basis. The group dialogues about changes and revisions to the assessment tool. A sub-group began working on training for clinical supervisors in how to provide clinical supervision regarding treatment planning.

- (3) **Performance Measures.** The BSATP established a team comprised of the Data Manager, clinical staff and DASIS Coordinator to begin developing extraction procedures and protocols for the National Outcome Measures. Draft protocols were completed in June 2005 and the measures were integrated into other existing reports including the Medicaid Quality Management Plan and the Annual Substance Abuse Report to the Legislature.

- (4) **Other Initiatives.**

- **Child Welfare Assessment and Referral.** The standardized Core Assessment was adopted by the Arizona Families F.I.R.S.T. statewide program for substance abusing families entering the child welfare system and substance abusing families receiving cash assistance through Temporary Assistance for Needy Families (TANF). RBHA providers delivered training to AFF providers in use of the new tool throughout 2005.
- **Criminal Justice Assessment and Referral.** A version of the Core Assessment was drafted for use by the Arizona Department of Corrections. This tool is intended to support comprehensive and seamless re-entry planning for offenders leaving prison settings and entering COOL services in the community. The tool will be completed in the fall 2005.
- **Co-Occurring Disorders.** In order to improve delivery of on-demand, competent substance use disorders services for adults with a serious mental illness, the BSATP funded five substance abuse provider agencies in Maricopa County to establish “co-located” co-occurring disorder specialists as clinic sites serving SMI adults. The specialists operate in teams of two at each of 15 clinics, providing engagement services, individual and group discovery, action and maintenance services and triaging consumers that require specialty addiction care in community residential treatment. This initiative will be rolled out to all 22 case management sites during FY 2006.
- **Reducing Cultural Barriers to Care.** Cultural Competency Advisory, Training, Data and Interpretation/Translation meetings occurred regularly. Membership of the committee includes family members, persons who are deaf or hard of hearing and behavioral health recipients. The Training Subcommittee is reviewing training curricula utilized through the T/RBHA system. Using the National Association of

State Mental Health Program Directors' Tool, the results of ADHS self-assessment of cultural competency activities were used to update the cultural competency plan. The Cultural Competency Plan has been shared and is being implemented jointly with the T/RBHAs and DBHS staff. ADHS has been working with CSAT to focus on identifying a self-assessment tool for the RBHAs.

- **Adult Recovery Teams.** Throughout the system, each behavioral health recipient is assigned a clinical liaison who is responsible for overseeing the pulling together of a team of involved parties providing input based on recipient and family needs. ADHS is intensifying the expectation that consumers and families will be actively involved in developing and directing their own care. The service plan and/or interim service plan is developed and implemented with collaborative participation with the involved parties. Monitoring of the RBHAs includes verifying through case file review that the service plans were developed and implemented with collaborative participation and that there is documentation of communication between team members.
- **Family Involvement.** A technical assistance document was developed on sharing information with families. It is accessible through the Department of Health Services web page.
- **Substance Abuse Recovery Support Specialists.** DBHS Bureau for Substance Abuse, with grant support through CSAT, held three focus groups to elicit information for a training curriculum for peer workers and agencies that hire peer workers in substance abuse settings. The Bureau prioritized \$650,000 from an increase to the SAPT Block Grant to expand the number of substance abuse providers that recruit and hire peer workers in all RBHAs. As of July 2005, more than 85 peer staff are working in substance abuse detoxification, residential, outpatient and methadone settings across the state. The goal of the peer program is to reduce access barriers to care and provide peer-driven recovery supports while in treatment, including linkages with the on-going recovery community.
- **Stigma Reduction.** The ADHS/DBHS conducted a stigma workshop in July 2005 through the PATH program. The two-day training addresses stigma within the behavioral health system and strategies for reducing stigma. A Steering Committee was established to assist DBHS in developing a statewide stigma reduction plan. Chaired by a BSATP staff, the Committee will include a member of Al-Anon, other family involvement organizations and consumer members.

FY 2006 INTENDED USE:

OBJECTIVE: Continue to identify and assess potential access barriers to ensure individuals and families are referred to and receive the most appropriate services.

ACTIVITIES:

- (1) Utilize outcomes monitoring data to identify populations, regions with low penetration.
- (2) Utilize appointment standards data to identify regions with potential access barriers.
- (3) Continue collaboration with a variety of stakeholders to ensure rapid and seamless access to services for critical populations.

OBJECTIVE: Continue initiatives to improve engagement and retention in treatment services

ACTIVITIES:

- (1) Continue development of substance abuse recovery specialist workforce.
- (2) Continue initiatives to improve engagement through Cultural Competency, stigma reduction and family involvement.
- (3) Continue co-located co-occurring disorder specialist expansion in Maricopa County.

GOAL # 11. -- An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FY 2003 (COMPLIANCE):

OBJECTIVE: Continue support and delivery of state of the art training programs for treatment and prevention staff.

ACTIVITIES:

- (1) Provide continued support to the DBHS Training Unit in implementing training on Covered Services and new DBHS policy.
- (2) Co-sponsor the fourth Annual Substance Abuse Summer School in August 2003.
- (3) Identify opportunities to provide training to professionals in co-occurring disorders, family-centered treatment and adolescent substance abuse services.
- (4) Provide training to behavioral treatment and prevention staff and related organizations in the development of support services.
- (5) Provide basic and advanced prevention training to the field, including needs assessment, program design, research-based strategies and evaluation.

COMPLIANCE:

- (1) **Contracts/Policy.** ADHS/DBHS continued to provide statewide leadership in workforce development through multiple training events hosted by the Division's Training Unit during 2003 and through direct clinical and prevention services training activities. Language requiring RBHAs to promote and provide core training in areas essential to the ADHS/DBHS contract remained in place during FY 2003. In particular, ADHS/DBHS implemented an 8-hour training program in the fall 2003 on the Core Assessment, the single standardized assessment tool required for use by all agencies for all behavioral health populations effective January 2004. An additional, 8-hour standardized track was developed for behavioral health technicians who would subsequently become privileged to conduct core assessments. Core assessment training and the enhancement of clinical skills for BHT level staff continued through 2004.
- (2) **ADHS/DBHS Training Unit.** During 2003-2004, trainings were provided through the centralized Training Unit on "Psychotropic Medication Informed Consent", and "Network Sufficiency Analysis using the Arizona Logic Model". A major initiative of the Training Unit during 2003-2004 was organization of multiple training events for RBHAs and provider staff on the new ADHS/DBHS Strengths Based Behavioral Health Assessment and Service Planning Process. The Unit obtained a CSAT Technical Assistance grant to assist in development of training curriculum, and worked closely with the Pacific-Southwest ATTC to develop video modules for Behavioral Health Technicians and Behavioral Health Professionals on use of the assessment tool. Enhanced 8-hour training for Techs in the fundamentals of diagnosis was also developed. The training program is required for all staff that will conduct the new standardized core assessment or serve as Clinical Liaisons (e.g. single point of care coordination) in the

public behavioral health system. As of June 2004, approximately 6,000 BHTs and BHPs were trained across the state.

(3) **Best Practice.** The BSATP continued to identify opportunities to provide and support training and workforce development programs focused on best practice in substance use disorder treatment and prevention services. Examples include:

- **Arizona Substance Abuse Summer Institute:** In August 2003, ADHS/DBHS co-sponsored the Fourth Annual Summer Institute in Sedona, Arizona. This Institute has emerged as the premier training and networking opportunity in the state, and was attended by more than 375 clinicians, stakeholders, consumers and agency staff, as well as the Governor of Arizona and the Director of the Department of Health. Training tracks focused on adolescent and women's services and best practices in addictions treatment. Continuing Education Credits were provided through the Pacific Southwest ATTC at the University of Arizona. A range of TA and trainings was designed to strengthen cultural appropriateness of services.
- **Co-Occurring Disorders:** During 2003, Dr. David Mee-Lee provided training on ASAM criteria and co-occurring disorder assessment and treatment in Tucson, Sierra Vista, Flagstaff and Yuma. The BSATP Chief and Value Options provided additional ASAM training to clinicians throughout Northern Arizona in April 2003.
- **Peer Support Training/Technical Assistance Day:** In November 2003, ADHS/DBHS hosted a meeting with support from CSAT. Dr. Stephen Moss and Katherine Hudson, from Health Systems Research, facilitated the meeting, entitled "Delivering Peer & Family Services in Substance Abuse Settings". David Loveland, Director of Research at Fayette Companies, a firm providing comprehensive mental health and substance abuse services, was a guest participant. The event's purpose was to promote the use of peer workers throughout the substance abuse treatment system. The attendees were RBHA substance abuse coordinators, select provider representatives, and peer and family support workers.
- **Disaster Mental Health Symposium.** In September 2003, a symposium sponsored by the FEMA Rodeo-Chediski Disaster Mental Health Grant was held in Flagstaff, Arizona. The Symposium was titled "Communities at Risk: Arizona's State of Disaster". Topics included: Administrative Challenges Faced in the Rodeo-Chediski Fire, The White Mountain Recovery Partnership in Action, Unique Training Requirements for the Behavioral Health Professionals in Disaster, and The Stakeholders' Role in Response and Recovery. The Symposium was designed to share disaster experiences resulting from the fire and address future state needs in disaster mental health and long term disaster recovery. Approximately 250 behavioral health professionals from across Arizona attended.
- **Annual Prevention Provider Meeting.** The Office of Prevention provides leadership in the development of a well trained, prepared workforce, including hosting the Annual ADHS Prevention Provider Meeting. This year, the meeting focused on the application of the Arizona Youth Survey to the development of provider programs, incorporation of the core evaluation instruments into program evaluation, correlating programs with research based strategies, covered services, community development, and cost benefit analysis. Additionally, key initiatives across the state such as targeting programs to risk factors common to both substance abuse and child abuse were discussed. The CSAP project officer was able to attend the meeting this year

and share her insights with participants as well. With over 180 registrations, prevention agencies across the state were well represented.

- **Core Prevention Training.** The Department worked in collaboration with RBHAs and the Arizona Drug and Gang Prevention Resource Center (ADGPRC) to ensure that “Basic Skills” training was available to prevention professionals in each region at least once annually. The majority of prevention professionals across the state have successfully completed the training.
- **Advanced Risk and Protective Factor Training.** The Department worked in collaboration with RBHAs and the ADGPRC to ensure that “Advanced Risk and Protective Factor” training are available to prevention professionals in each region at least once annually. The majority of prevention professionals have successfully completed this training.
- **Collaborative Efforts.** The Department collaborated with the Arizona Suicide Prevention Coalition, Arizonans for Prevention, the Arizona Prevention Resource Center, the Arizona Criminal Justice Commission, and the Governor’s Office to educate the prevention field and other stakeholders to increase knowledge of prevention strategies.
- **Other Training.** In addition to “Basic Skills” and “Advanced Risk and Protective Factor” training, prevention providers received education and training on topics such as elder issues, domestic violence, child development, prevention of addiction, child abuse, strengths based programming, methods of engaging families, communication skills, depression, suicide risk factors, safety, recreation activities, sex offenders, street drugs, and sexual assault.
- **Needs Assessment and Evaluation.** Needs assessment data is posted on the ADHS web site. Training in evaluation and application of the statewide needs assessment was provided during the annual statewide meeting for prevention providers. Regional Behavioral Health providers provided technical assistance to providers in the application of needs assessment data. The Governor’s Office initiated an intergovernmental agreement with the ADHS to assist with the social indicator study. They also provided significant funding to the Arizona Criminal Justice Commission for the next administration of the Arizona Youth Survey.

FY 2005 (PROGRESS):

OBJECTIVE: Continue support and delivery of state of the art training programs for treatment and prevention staff.

ACTIVITIES:

- (1) Continue contractual requirements with RBHAs to provide core training in areas critical to the ADHS/DBHS contract.
- (2) Enhance quality, consistency of training events and ensure focus of training on issues critical to the ADHS/DBHS through the statewide leadership of the Training Unit.
- (3) Continue workforce development focus on best practices in addiction services including co-occurring competencies, family centered practice, adolescent treatment and recovery models.

- (4) Continue support for the annual Summer Substance Abuse Institute.
- (5) Maximize technical assistance days through the Center for Substance Abuse Treatment.
- (6) Ensure Core Prevention Training is provided with consistency across sites, through an annual training of trainers.
- (7) Maintain an infrastructure to support on-going technical assistance to the RBHAs in program design, research based strategies, and evaluation among other prevention related topics.
- (8) Provide exposure to national experts/initiatives/research through the annual statewide prevention providers meeting and other venues.
- (9) Develop and implement training for RBHAs and providers on evidence-based practices in primary prevention and treatment for persons at risk for suicide and their families including survivor groups.

FFY 2005 PROGRESS:

Treatment Services

- (1) **Contracts/Policy.** Language requiring RBHAs to promote and provide core training in areas essential to the ADHS/DBHS contract remained in place during FY 2005.
- (2) **Best Practice.** The BSATP continued to identify opportunities to provide and support training and workforce development programs focused on best practice in substance use disorder services. Through the Pacific Southwest-ATTC, multiple events were held focusing on clinical skills development in motivational interviewing, use of the ASAM criteria and various evidence-based treatment models including Community Reinforcement and Adolescent Cannabis Treatment. Other focus areas included:
 - **A Day with David Mee-Lee.** In September 2004, the BSATP hosted Dr. David Mee-Lee for a daylong workshop on motivational engagement and individualized assessment and service planning. This workshop was restricted to staff of ADHS/DBHS, the Arizona State Hospital, ADHS/Behavioral Health Licensure, the Arizona Office of the Governor and representatives from the adult and juvenile corrections and the probation system.
 - **Critical Incident Stress Management.** In September 2004, the ADHS/DBHS in collaboration with ADHS/Public Health Services provided Critical Incident Stress Management (CISM) training. This series is funded through the Arizona's HRSA Emergency Preparedness Grant award and is being presented to benefit all state Regions. The training targets the behavioral health system workforce and hospital emergency department personnel to promote familiarity between the systems. This training will continue in the summer of 2005.
 - **Summer Institute.** In collaboration with the University of Arizona Pacific-Southwest ATTC, the BSATP co-sponsored the fifth Annual Summer School on Substance Abuse in July 2004. This three-day conference attracted nearly 400 clinicians, consumers and professionals to Sedona and featured a keynote by Dr. H. Wesley Clark and a panel presentation on substance abuse policy by the ADHS Director and the Directors of juvenile corrections and child protective services. Workshop tracks

included peer and family support, the New Freedom Commission Report and cultural competence. A pre-institute clinical skills intensive was offered for the first time and featured one-day sessions on Brief Strategic Family Therapy and Motivational Enhancement Therapy.

- **CSAT Technical Assistance.** In 2005, the BSATP, with support from CSAT's Technical Assistance program, offered the Summer Institute, a two-day workshop on narcotic drug treatment including buprenorphine training for physician staff and the Arizona Drug Court Conference. In addition, CSAT participated in the development of training curriculum for the new core assessment and service planning process, and is currently a participant in the development of curriculum for peer workers in substance abuse treatment agencies.
- **Cultural Competency Training of Trainers:** The Cultural Competency Advisory Committee (CCAC) composed of DBHS Staff, RBHA's Cultural Experts, and Behavioral Health Advocacy Representatives around the state see the need for developing training in cultural competency to improve services for behavioral health clients, and to instill this concept into policies and procedures that influence treatment practice statewide. CCACs consultants, Dr. Pierluigi Mancini and Dr. Delia Saldana, funded by CSAT, developed the "Cultural Competency Assessment Tool" and a "Curriculum for the Training of Trainers". They will facilitate "Training of Trainers" in the fall 2005, in Phoenix. Thirty attendees will include RBHA representatives and DBHS Staff.
- **Stigma Reduction Training.** The federal PATH Grant supported a two-day "Stigma Reduction Training" in August 2005 in Sedona. A long-term planning and strategy development process to inhibit prejudicial beliefs about individuals who have been identified with behavioral health problems will follow that event. The 12-member Steering Committee for this initiative includes family members, consumers and advocacy representatives including Al-Anon.
- **A Statewide Celebration of Courage.** Held in April 2005, this consumer designed conference featured peers talking with peers about the power of peers. More than 600 consumers of substance abuse and mental health services participated in plenary and workshop sessions on peer-delivered services.

Prevention Practices

(1) **Contracts/Policy.** The revised *Framework for Prevention in Behavioral Health* was released in June 2005. This document details requirements and guidelines for tribal and regional contractors on training needs for prevention professionals, core competencies of prevention staff at varying services and administrative levels as well as annual training requirements and is incorporated by reference in the ADHS/DBHS contract.

(2) **Prevention Coordinators Meetings.** ADHS met with RBHAs and tribal contractor prevention representatives on a monthly basis to provide on-going technical assistance, monitor and coordinate services, and advance prevention initiatives. Approximately 10 RBHA prevention coordinators participated in the monthly meetings, at which, planning for prevention programming, discussions of prevention funding allocations, and *Prevention Framework* development occurred. The group also engaged in on-going discussions around the need for a uniform basic skills training for prevention

specialists working within the State behavioral health system. The Office of Prevention, while recognizing the uniqueness of each RBHA as they develop basic skills training, realizes that there is a need for a uniformity in training that ensures prevention specialists have the required skills necessary to implement effective programming in their communities. The Office of Prevention continues to work with the RBHAs in meeting this challenge.

(3) **Best Practice.** The Office of Prevention either sponsored or facilitated the following trainings and presentations over the course of the year:

- **Summer Institute.** During the Fifth Annual Summer Institute, two workshops were conducted entitled *Integrating Suicide Prevention Into Existing Substance Abuse and Parenting Issues in Substance Abuse*. The first workshop presented information on the characteristics of high-risk groups, standards for effective programs in suicide prevention, and the Department's plan/priorities to address this important issue. The second was concerned with the service needs of substance abusing parents, preventing abuse and neglect of children in households with substance abusing parents, and the use of health promotion.
- **Suicide and Substance Abuse Training.** Information on the ADHS/DBHS plan to reduce suicide in Arizona, standards for effective risk assessment, interventions and treatment were presented (October 2004) to the staff of the Phoenix Indian Medical Center. Several suicide prevention trainings occurred during December 2004 which covered the State plan and priorities in reducing suicide, the history of suicide in the state, characteristics of high-risk groups, risk and protective factors, social marketing methods, and the application of the Arizona Logic Model to program design and evaluation. Several suicide prevention trainings were also provided (April 2005) to prevention providers covering an overview of evidence based practices and promising programs (i.e., TeenScreen, OPTIONS, QPR, Positive Paths).
- **Tribal Prevention Coalition.** In December 2004 the Arizona Suicide Prevention Coalition's Native American Committee held its first bi-annual retreat. Approximately (30) persons attended the event. Participants represented nine of Arizona's 22 tribal nations, prevention providers, and other interested agencies. Topics covered were critical incidence stress debriefing, community mobilization, and strategic planning. A second retreat was held in June 2005. Approximately 35 persons attended the event, representing 12 of Arizona's 22 tribal nations, prevention providers, and other interested persons and agencies. Topics included strategic planning, information related to Arizona's Native American population from the 2004 Arizona Youth Survey, and a discussion on reincorporating traditional culture and spirituality into Native American lives.
- **Core Training.** *Skills for Effective Prevention Training* was conducted in February 2005, in which prevention specialists from the PGBHA provider network and the Pascua Yaqui Centered Spirit Program attended. This training covered risk and protective factors, IOM domains, community needs and resource assessment, cultural competency, and program evaluation. Pre and post-tests were administered and results indicated an increase in basic skills knowledge of prevention.
- **Adolescent Mental Health.** In March 2005, staff of the Office participated in a workshop entitled *Is Anyone Out There?* which was hosted by the Arizona Adolescent Health Coalition. Discussion focused on how to obtain mental health

services for adolescents.

- **Program Evaluation.** In March 2005, in collaboration with West CAPT, the *Evaluation 101: Approaches to Prevention Evaluation* training was presented to prevention providers. Topics addressed: program evaluation basics and logic model design.
 - **Sponsorship.** The Department sponsored six members of the Arizona Suicide Prevention Coalition to attend the American Association of Suicidology Annual Conference (April 2005). Attendees received training on effective prevention programming and staff development to advance the State's suicide prevention plan.
- (4) **Annual Meeting.** The annual statewide meeting, which targets prevention providers and RBHA prevention staff, took place on June 15, 2005. Training topics addressed at this all day event included: Understanding the Role of Culture in Substance Abuse, Suicide, and Child Abuse Prevention; Working with LGBTQ Youth & Families; Successfully Engaging Native American Communities; Five Skills for Creating Culturally Appropriate Prevention Programs; Evidence-Based Practices in Suicide Prevention; Techniques for Conducting a Basic Needs Assessment; Connecting Generations: The Challenges and Successes of a Prevention Program Focused on Diverse Populations; and Community Mobilization: Working with Minorities and Grassroots Organizations to Create Change. More than 160 people attended representing over 50 prevention programs. Evaluation forms were collected from 85 participants, and an overall rating of 4.41 on a 5 point scale was given for the meetings overall success.

FY 2006 (INTENDED USE):

OBJECTIVE: Continue support and delivery of state of the art training programs for treatment and prevention staff.

ACTIVITIES:

Treatment

- (1) Continue contractual requirements with RBHA's to provide core training in areas critical to the ADHS/DBHS contract.
- (2) Enhance quality, consistency of training events and ensure focus of training on issues critical to the ADHS/DBHS through the statewide leadership of the Training Unit.
- (3) Continue workforce development focus on best practices in addiction services including co-occurring competencies, family centered practice, adolescent treatment and recovery models.
- (4) Continue support for the annual Summer Substance Abuse Institute.
- (5) Maximize technical assistance days through the Center for Substance Abuse Treatment.

Prevention

- (1) Develop and disseminate a uniform prevention skills training entitled *Skills for Effective Prevention* to Regional Behavioral Health Authority provider networks and tribal contractors.

- (2) Establish a training committee comprised of RBHAs, tribal contractors, and prevention providers to ensure the advancement of effective prevention programs in the State.
- (3) Continue to fund trainings for the Arizona Suicide Prevention Coalition's Native American Committee in identifying effective and evidenced based programs that will combat the second leading cause of death, suicide, for Native American men ages 14 – 35.
- (4) Maintain an infrastructure to support on-going technical assistance to the RBHAs in program design, research based strategies, and evaluation among other prevention related topics.
- (5) Provide exposure to national experts/initiatives/research through the annual statewide prevention providers meeting and other venues.
- (6) Develop and implement training for RBHAs and providers on evidence-based practices in primary prevention and treatment for persons at risk for suicide and their families including survivor groups.

GOAL # 12.-- An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FY 2003 (COMPLIANCE):

OBJECTIVE: Develop strategic partnerships that emphasize coordination, collaboration and integration of social, educational, medical and other services to substance abuse treatment clients and prevention participants.

ACTIVITIES:

- (1) Continue contract language requiring coordination of care for substance abuse treatment clients and monitor activities through the annual Administrative Review.
- (2) Continue participation on the Governor's Drug and Gang Policy Council, and the Council's Working Group to ensure coordination of services and supports across multiple state agencies.
- (3) Continue participation on the Steering Committee for the Joint Substance Abuse Treatment Fund to ensure coordination of care for child welfare families who receive AHCCCS supported treatment through the RBHAs.
- (4) Renew the Memorandum of Understanding with the Arizona State Lab and the Office of HIV/AIDS to continue provision of Ora-Shure to agencies funded to conduct HIV Early Intervention Services.
- (5) Continue participation in the co-occurring treatment initiative in partnership with the DBHS Bureau for Persons with a Serious Mental Illness.
- (6) Continue development of the practice improvement guidelines for adolescent substance abuse with the DBHS Bureau for Children's Services.
- (7) Continue focus on expanding and improving services through the COOL program.
- (8) Continue community development as a priority area in targeted behavioral health communities.

COMPLIANCE:

- (1) **Contracts/Policies Requiring Coordination of Care.** Coordination of care with primary care providers was placed on the DBHS strategic action plan in 2003 with a focus on improved information-sharing and referral processes for consumers with chronic health care conditions. The ADHS/DBHS Provider Manual, released in September 2003, detailed specific conditions for which coordination with healthcare providers is required, including change in medications and crisis events. BSATP staff continued their participation in quarterly meetings of the RBHAs with local AHCCCS health plans to ensure identification and resolution of issues related to information sharing, medication and the disposition of health plan referrals to behavioral health providers. RBHA performance on coordination of care was assessed in the annual Independent Case Review in 2003 and 2004, with specific performance improvement actions resulting.

(2) **Arizona Drug and Gang Policy Council and Working Group.** The Governor's Division of Substance Abuse Policy undertook a major re-design of the Governor's Drug and Gang Policy Council and Working Group during 2003. The re-design resulted in a re-focusing of the Council and Working Group functions around implementation of evidence based prevention and substance use disorder services in the areas of policy, data and practice. The ADHS Director chaired the policy subcommittee of the Council. The Working Group undertook a strategic visioning project in the spring 2003 to establish a new framework for substance abuse policy and the Council's scope under the new Governor. The BSATP Chief and the Prevention Manager participated on several subcommittees whose major accomplishments are summarized below.

- Policy Committee - established a state policy statement on substance abuse.
- Substance Abuse Practice Committee - established agency goals and priority areas for expanding evidence-based practices.
- Data Committee - established a core set of outcome indicators across all state agencies.

(3) **Coordination of Care for Child Welfare Families.** The Arizona Governor launched a statewide reform of child welfare services in 2003. A key recommendation of the reform Commission was expanding the provision of family-centered substance abuse treatment programs through revenue sources other than the TANF-funded Arizona Families FIRST. The AFF Model provided a continuum of community-based, family-centered substance abuse treatment services for parents reported to Child Protective Services (CPS) whose substance abuse had been identified as a significant barrier to maintaining or reunifying the family. In addition to core substance abuse treatment and recovery services, other essential support services were provided to assist the entire family. In response to the Commission recommendation, ADHS/DBHS prioritized \$1.5 million in SAPT Grant funding for non-Medicaid dependency cases referred from CPS in Pima and Maricopa Counties.

The BSATP continued to work closely with the Department of Economic Security to ensure coordination of care for child welfare families who receive AHCCCS supported treatment services through the RBHAs. Nine providers received contracts through the Department of Economic Security/Child Protective Services to implement a community substance abuse prevention and treatment program. For the year ending March 2003, 75% of referred families are TXIX eligible/enrolled and received their treatment services through the RBHAs. The RBHAs coordinated locally to ensure that assessments were not duplicated and that supportive services, such as long-term housing, were available through the Families FIRST TANF funds made available to TXIX clients.

Multiple cross-agency trainings and meetings were held through SFY 2003 to clarify eligibility and service requirements, ensure local coordination of care and promote a family recovery model for substance abuse treatment services. Due to budget issues in the 2003 General Session, the ADHS allocated \$300,000 in FY 2002 SAPT Block Grant funds to the Department of Economic Security to support program service delivery through September 2003.

(4) **HIV Early Intervention Services.** The Memorandum of Understanding with the Arizona State Lab and the ADHS Office of HIV/AIDS was renewed. This MOU provides access to bulk purchasing of OraSure kits and free sample processing to agencies funded

to conduct HIV Early Intervention Services. In 2003 and 2004, the MOU was expanded to incorporate provision of Rapid Testing.

(5) **Co-Occurring Treatment Initiative.** The BSATP continued participation in the state panel for co-occurring treatment. The state panel disbanded in March 2003 following closure of the CMHS grant. BSATP has designated an FTE position for continued work with regional panels and the development of RBHA systems of care for persons with multiple disorders. During 2003, activities included statewide provision of specialized training by Dr. David Mee-Lee (Yuma, Flagstaff, Benson, Tucson, Phoenix).

(6) **Practice Improvement Guidelines for Adolescent Substance Abuse Treatment.** A team representing the BSATP, the Children's Bureau and the DBHS Medical Director's Office continued development of new practice guidelines for treating adolescent substance abuse. The Practice Improvement Protocol (PIP) was finalized and published in June 2004.

(7) **COOL Program.** ADHS continued its interagency service agreement with the Arizona Department of Corrections for the Correctional Officer/Offender Liaison Program (COOL). During FY 2003, parole officers referred 6,467 persons leaving prison to the COOL program and 4,560 (75%) were subsequently screened and enrolled in substance abuse treatment. The collaborative agreement with Arizona Department of Corrections was enhanced for fiscal year 2003 to include expansion of the COOL program to include 20 transitional supported housing units in Maricopa County. This enhancement also added four FTE staff positions through Value Options to assist parole officers in accessing community resources. The positions were housed in local parole offices and worked collaboratively with COOL staff at the RBHAs to ensure an appropriate mix of re-integration and treatment services for offenders on parole. The BSATP COOL liaison also provided presentations in the prison setting as part of the parole officers' bi-annual training requirement. Substance abuse service availability was also expanded through the addition of new COOL funding and conversions of COOL participants to the TXIX program.

(8) **Community Development Focus.** The Office continued active involvement with the Arizona Suicide Prevention Coalition, Arizonans for Prevention, and the Arizona Adolescent Health Coalition during 2003.

- **Older Adult Initiative.** The Office of Prevention supported implementation of substance abuse prevention programs targeting older adults in each region of the state. The BSAPT participated in a CSAP forum in Florida to discuss the needs of older adults. ADHS/DBHS, RBHAs, and providers focused on aligning prevention programs targeting older adults with research-based strategies. In September 2003, the Department co-sponsored a forum with CSAP on the Older Adult Initiative in collaboration with the RBHAs, American Association for Retired Persons, local Areas on Aging and other organizations.
- **Substance Use Outcomes.** The Office of Prevention initiated a strategic realignment of prevention during the fall 2003 with an emphasis on enhancing the availability of programs addressing the joint risk factors for substance abuse, child abuse and suicide prevention. Data from the Prevention Needs Assessment was used to isolate areas with high rates of risk factors for these issues and to measure the availability of programming. Collaborations with the Arizona Suicide Coalition and the Department of Economic Security assisted in this initiative.

Regional Community Development Strategies

Community Partnership of Southern Arizona

- **Environmental Strategies.** In 2003, CPSA required all prevention programs in their region to focus on one or more of three regional goals established by the RBHA following a comprehensive needs assessment. One goal was to decrease laws, policies, and/or norms favorable to substance abuse. To expand providers understanding, CPSA provided training in environmental strategies in September 2003.
- **Tribal Focus.** CPSA enhanced collaboration with the Tohono O'Odham Nation by issuing an RFP for services for the Tohono O'Odham population. The RFP was reviewed and accepted by the Tribal Council and five of the district councils.
- **Parent Network.** CPSA developed a county-wide Parent Resource Network in Cochise County. The Parent Resource Network commenced work on a community needs assessment related to child welfare issues.

ValueOptions

- **Latino Youth Initiative.** VO was actively involved with in the state drop-out prevention initiative, and continued its focus on targeting prevention providers to zip code areas with high prevalence of indigent, Hispanic youth. This effort included expansion of prevention resources to focus on natural support organizations in communities and schools with large numbers of Hispanic families.

Pinal Gila Behavioral Health

- **Pinal Town Hall.** Co-sponsored a Pinal County Town Hall meeting in collaboration with other community stakeholders to examine social issues impacting Pinal County and develop a strategic plan to address problems.

FY 2005 (PROGRESS):

OBJECTIVE: Develop strategic partnerships that emphasize coordination, collaboration and integration of social, educational, medical and other services to substance abuse treatment clients and prevention program participants.

ACTIVITIES:

- (1) Continue participation on the Governor's Drug and Gang Policy Council and Working Group to ensure coordination of services and supports across multiple state agencies.
- (2) Continue refining contract language, policy and procedure to ensure appropriate coordination of care for substance abuse treatment clients and monitor RBHA performance.
- (3) Continue current collaborative partnerships with Arizona Department of Corrections, Child Protective Services and adult SMI services to ensure the best and most appropriate care for persons with substance use disorders.

- (4) Continue community development as a prevention priority area in targeted behavioral health communities.
- (5) Strengthen statewide RBHA and provider partnerships with education, child welfare, older adult, and suicide prevention organizations.

PROGRESS:

- (1) **Governors Drug and Gang Policy Council.** The Governor's Drug and Gang Policy Council underwent a sunset review during the 2005 Legislative Session. The Legislature felt that the Council had accomplished many of its initial goals and elected not to continue the role of the Council effective at the close of the 2005 Legislative Session. BSAPT staff continued to participate in the Governor's Program and Practice Subcommittee, comprised of multiple state agencies. The committee reviewed and developed revised statewide standards for effective practices, which were later incorporated into DBHS' revised *Framework for Prevention in Behavioral Health*. In addition, ADHS staff participate in the newly formed Strategic Prevention Framework State Incentive Grant (SPF SIG) Advisory Council.
- (2) **Contracts/Policy.** Language detailing coordination of care requirements remained in place in RBHA contracts and the ADHS/DBHS Provider Manual in 2003. In follow-up to the 2003 and 2004 Independent Case Reviews, an information sharing template was developed by the DBHS Medical Director identifying conditions for which referral and communication with AHCCCS acute care health plans is required. The template was implemented in 2004-05 and reassessed in the 2005 ICR study.
- (3) **Care Improvement.** The BSATP continued to participate in a variety of collaborative initiatives designed to expand access to substance abuse treatment for priority state populations and improve coordination among allied state systems, including criminal justice, child welfare, housing and public health. During this period, the COOL contract remained in place with Arizona Department of Corrections and the Intergovernmental Agreement with Department of Economic Security remained in place. These documents provide guiding principles and practices for ensuring rapid access to treatment for offenders leaving prison settings and parents referred by child protective services.

The ADHS/DBHS focus on continuous improvement in care quality for persons with co-occurring disorders resulted in a specific initiative in Maricopa County to "co-locate" substance abuse provider agency staff at clinic sites serving persons with serious mental illness. The "co-location" was intended to close the gap between identification and access to services for SMI adults by providing on-site engagement, active treatment and maintenance groups and individual services, as well as technical expertise to SMI treatment teams working with co-morbid adult consumers. As of July 2005, fifteen of 22 clinic sites had co-located substance abuse providers.

- (4) **Tribal Coordination.** The Office of the Governor hosted the Tribal Summit on Substance Abuse in May 2005. Tribal Summits are provided on a variety of issues of significance to tribes, including water rights, housing infrastructure and diabetes, as a venue for direct planning and issue resolution between the state executive office and the leadership of Arizona's 22 tribes. The BSATP chief provided a presentation on substance use prevalence and impacts on native lands, including a specific focus on methamphetamine. ADHS/DBHS has committed to increased targeting of new and

unobligated SAPT grant funds to tribal communities. During 2005, several supportive events were developed under BSAPT leadership to address methamphetamine issues on reservation lands including the Hopi Community Drug Summit (April 2005) and the first in a series of tribal First Responder Workshops on Methamphetamine held on Navajo Nation (August 2005). The First Responder Workshops were developed and co-presented by the Pacific Southwest ATTC and the BSAPT.

(5) **Community Development.** Expectations regarding prevention provider involvement in community development are outlined in the revised *Prevention Framework for Behavioral Health*, which was released in June of 2005. The Office of Prevention developed the document in collaboration with a variety of community prevention partners including the Arizona Criminal Justice Commission, Arizona State University, Governor's Office, Department of Economic Security, Office of Women and Children's Health, Tobacco Education and Prevention Project, RBHAs, and providers. The Framework defines contracting and operating standards for prevention providers. DBHS also revised the annual Prevention Evaluation Report to align with new Federal guidelines from the Performance Partnership Block Grant. The newly defined emphasis on three targeted areas of prevention (substance abuse, child abuse, and suicide) resulted in increased and enhanced services and programs addressing these mutual risk factors.

Provider involvement in community development is monitored in annual evaluation reports submitted by the RBHAs to ADHS and via monthly RBHA Prevention Coordinator meetings. All enhanced and expanded programs have been asked to coordinate services with local and state coalitions addressing the same issues and populations. In addition, DBHS staff, RBHA Prevention Coordinators, and providers participate in Arizonans for Prevention and the Council of Human Service Providers.

(6) **Partnerships.** Prevention of substance abuse related suicide is an integral part of the Division's 2004-2009 Strategic Plan. DBHS convened a workgroup of internal and external stakeholders, including RBHA clinical staff, providers, AHCCCS health plans, crisis hotline staff, Arizona Suicide Prevention Coalition members, youth and mental health care organizations. The workgroup researched and identified effective practices for suicide prevention, risk assessment, and treatment, and drafted a set of guidelines for conducting effective suicide risk assessments, with the ultimate goal of improving the quality and coordination of care for persons at risk for suicide and their families.

DBHS' partnership with Arizona Suicide Prevention Coalition flourished in 2005. DBHS staff facilitated strategic planning for the Coalition and worked with the Suicide Prevention Resource Center to organize a statewide team representing Arizona at the SPRC Planning Conference for Suicide Prevention for Public Health Regions 9 & 10. The Department also awarded scholarship funds to the Mental Health Association of Arizona for several Coalition members to attend the annual American Association of Suicidology conference. Both conferences provided an opportunity for professional development, networking, and strategic planning to advance the statewide suicide prevention plan. DBHS' involvement in the Coalition has resulted in substantially increased membership, with 42 agencies and 6 individuals representing a total of 83 participants statewide. DBHS reconvened the Native American Committee, which meets monthly and includes representation from 12 tribes. Two Training Retreats sponsored by DBHS were held in December 2004 and May 2005, focusing on topics of Critical Incident Stress Management, spirituality and healing, and community development.

DBHS worked with the Arizona Suicide Prevention Coalition's Native American Committee to provide data on child abuse to the Governor's Office for Children, Youth and Families. In addition, DBHS facilitated a partnership between this committee and the Arizona Criminal Justice Commission, which resulted in a special report of the Arizona Youth Survey specific to tribal communities in Arizona.

The BSAPT allocated a portion of Federal Block Grant funds (\$245,000) to develop new programs and expand existing programs for prevention of substance abuse related suicide in December 2004. New programs targeted groups at high risk for substance abuse and suicide including Native American youth, older adults, and Gay, Lesbian, Bisexual, Transgender youth. Strategies included professional gatekeeper training for schools, caregivers, and other populations; peer education/youth leadership; public awareness and social marketing. DBHS staff provided quarterly trainings to prevention providers and technical assistance in program implementation.

The Department also continued its collaboration with the Behavioral Health and Aging Coalition, participating in quarterly meetings, attending the Governor's Conference on Aging, providing informational brochures for Senior Action Day at the Capitol, participating in internal strategic planning for ADHS' Aging 2020 Plan and assisting with BHAC strategic planning efforts.

FY 2006 (INTENDED USE):

OBJECTIVE: Develop strategic partnerships that emphasize coordination, collaboration and integration of social, educational, medical and other services to substance abuse treatment clients and prevention program participants.

ACTIVITIES:

- (1) Continue participation in Governor's Office activities, including the Strategic Prevention Framework and epi-work group to ensure coordination of services and supports across multiple state agencies.
- (2) Continue refining contract language, policy and procedure to ensure appropriate coordination of care for substance abuse treatment clients and monitor RBHA performance.
- (3) Continue current collaborative partnerships with Arizona Department of Corrections, DES/Child Protective Services, tribal communities and adult SMI services to ensure the best and most appropriate care for persons with substance use disorders.
- (4) Participate in review and implementation of performance improvement plans from the 2004 Independent Case Review involving coordination to care.
- (5) Continue community development as a prevention priority area in targeted behavioral health communities.
- (6) Strengthen statewide, Regional Behavioral Health Authority and provider partnerships with education, child welfare, older adult, and suicide prevention organizations.
- (7) Continue collaborative partnerships with the Arizona Department of Economic Security, the Arizona Department of Education, the Governor's Office Divisions of Drug Policy and Children, the Arizona Criminal Justice Commission, and other organizations

to improve the quality of prevention programs across the state, with special emphasis on the strengthening of child abuse prevention programs and use of prevention needs assessment data.

GOAL # 13.-- An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FY 2003 (COMPLIANCE):

OBJECTIVE: To use substance abuse treatment and prevention resources efficiently to meet established need and demand for services.

Treatment Needs and Capacity Assessment

ACTIVITIES:

- (1) Continue use of the Arizona Logic Model to assess current network capacity for treatment services.
- (2) Provide technical assistance to RBHAs to expand capacity to fill identified network gaps.

During SFY 2003, DBHS continued to use the Arizona Logic Model for Network Sufficiency as the primary focus of treatment needs assessment. The Logic Model synthesizes data across multiple domains to assess the sufficiency of the provider network to deliver appropriate services within required accessibility timeframes and quality of care standards. Data used include: (1) administrative data including enrollment, eligibility, penetration, timeliness of service (emergency appointments, referral to intake within 7 days, ongoing services within 23 days), cultural considerations and findings of the annual Independent Case Review of medical records; (2) structural and practice patterns data including utilization (encounters), provider network inventory and geo-mapping (3) consumer input data including complaints, grievances, and the biannual Consumer Satisfaction Survey. These elements are reviewed and synthesized to detect common themes, outliers and trends that indicate network gaps and are used to establish priorities for network development for each RBHA. A special analysis is conducted using wait list data for pregnant women and IDUs.

Overall, growth in the number of eligible and enrolled persons was enormous between June 2001 and June 2003. During this period, the total population of eligible adults rose by 100%. Substance Abuse/General Mental Health enrollment increased 128% statewide during this same period. Several areas were prioritized for development during SFY 2004 including: Therapeutic Foster Care for adults and children, access to methadone services, Medical Behavioral Health Day Programs for all populations, Level 1 Detoxification Services for adults, and Cognitive Rehabilitation Services. In addition, the BSATP prioritized development of Peer and Family Support Services for adults and families with substance abuse problems by virtue of a CSAT Technical Assistance grant.

As of April 2003, the following developmental activities occurred at each RBHA for the SFY 2003 period:

Community Partnership of Southern Arizona

- Established Level 2 crisis beds for children (8 beds)
- Supervised Day Respite for children in Santa Cruz County and Tucson

- Initiated Youth Substance Abuse Initiative (extended into SFY 2004)
- Established training plan and specialized consultations on co-occurring disorders
- Opened a new Level 1 detoxification continuum including 12 stabilization beds, 16 medical beds and 50 residential step-down beds
- Implemented the Mother and Child Addiction Service Team for intensive case management services
- Implemented a Performance Improvement Activity on methadone capacity
- Initiated a contract with Child Protective Services for substance abuse treatment for families who are involved in child welfare.

EXCEL Group

- Expanded outpatient service sites to East Yuma and Quartzsite
- Opened a Level 2 residential substance abuse facility
- Completed the Adolescent Substance Abuse Regional Plan including establishment of new programs and a Team Challenge ropes course
- Continued funding the social detoxification facility in Yuma

Northern Arizona Regional Behavioral Health Authority

- Added three Level 2 substance abuse residential beds in Prescott
- Converted three Level 1 subacute beds in Show Low to detoxification capacity
- Provided expanded funding for outpatient substance abuse groups and health promotion
- Undertook a re-design of the regional substance abuse continuum using the ASAM model
- Began discussions with a community stakeholder group in Flagstaff to address local needs for addressing public inebriation.

Pinal Gila Behavioral Health Association

- Specialized training on elderly substance abuse and suicide
- New outpatient substance abuse services for children in Apache Junction
- Established a contract with a Tucson provider for specialty women's services

Value Options

- Continued to work with the new central city detoxification provider to improve post-episode linkages with on-going treatment.
- The Substance Abuse Infrastructure Initiative fostered the following: purchasing a new van for the Pregnancy and Addictions Case Management Team, established a small business equipment fund, established a rotating pool of six benefit specialists, expanded intensive case management services to injection drug abusers who are non-TXIX.
- COOL Housing Program - established and filled the first 20 apartments in Maricopa County during the spring 2003. ValueOptions and the BSATP, working through the interagency service agreement with the Arizona Department of Corrections, initiated this first time use of sponsor-based housing for substance abusing adults.

Prevention Needs Assessment

ACTIVITIES:

- (1) Use findings from the CSAP Prevention Needs Assessment to improve targeting and focus of prevention services.

ADHS/DBHS conducted and required routine needs assessment for prevention services at the state, RBHA and local level. In 2003, the ADHS/DBHS completed its CSAP contract supporting the statewide prevention needs assessment and made all reports and findings available to RBHAs, providers and other interested stakeholders. County and state level summaries of social indicator and Youth Survey data were maintained on the ADHS website. The Office of Prevention met regularly with the Governor's Division for Substance Abuse Policy and Arizona Criminal Justice Commission (ACJC) to support multi-agency continuation of the social indicator and Youth Survey projects. ACJC expressed their intent to continue the risk and protective factor model for collection and reporting of student drug use survey data.

In 2003, the Office of Prevention initiated a review of the distribution of existing prevention resources in light of findings from the needs assessment. The review included a focus on the prevalence of key indicators of substance abuse in Arizona, including prevalence of severe substance related issues such as suicide and child abuse. These issues serve as indicators for regions with high levels of substance use for which no current survey based data collection exists.

Substance Abuse Outcomes. The 2002 Arizona youth survey was the main data source used by the Arizona Department of Health Services to assess substance abuse prevalence. According to the 2002 Arizona Youth Survey, alcohol was the most commonly used substance among youth in Arizona, followed by marijuana and tobacco. Arizona females had higher use rates of alcohol (30-day and lifetime use), cigarettes (30-day and lifetime use), inhalants (30-days), heroin (30-days), methamphetamine (lifetime) and ecstasy (lifetime) than males. When compared to National surveys, Arizona youth had somewhat higher regular/past month use rates of nearly all substances – alcohol, marijuana, inhalants, hallucinogens, methamphetamine, cocaine, steroids, heroin, barbiturates and ecstasy. Use of alcohol, cocaine, ecstasy, and marijuana was higher for Arizona youth than for youth nationwide. This data was shared with prevention providers and collaborative partners such as schools, statewide.

Substance Abuse Prevention Program Quality. As all of the Arizona Department of Health Services prevention programs were already targeting reduction of substance abuse, the Office of Prevention looked for opportunities to improve program quality. The weakest component of the substance abuse prevention efforts was in their evaluation. Less than half of all prevention programs were reporting outcomes on an annual basis. The Division initiated efforts to increase reporting of prevention program outcomes.

Risk Factors for Substance Use When Arizona youth were asked how much risk (health and otherwise) there was in using alcohol, tobacco and other drugs, students in Arizona generally believed that there is less risk in using alcohol, tobacco and other drugs (ATOD) than students nationwide. The greatest difference was in the perceived harm of smoking marijuana regularly. For all grades of the Arizona students surveyed, there was a

perception that marijuana was less harmful than was the perception of their national counterparts. This would indicate perception of harm would be an appropriate target for prevention programs. Several prevention programs are targeting perception of harm.

A review of risk and protective factors targeted by prevention programs in Arizona showed a basic disconnect between program level needs assessment, targeted risk and protective factors, prevention strategy, and evaluation. The Office of Prevention planned to further explore this problem with prevention coordinators.

Severe Substance use related problems. The Arizona Department of Health Services examined the prevalence of substance use-related problems, which are strong indicators of substance abuse, to identify populations to be targeted for substance abuse prevention efforts with limited resources available.

Suicide was identified as a substance abuse-related problem with a high rate of prevalence in Arizona. Suicide rates in Arizona were especially high among young Native American men, older White men, and young gay, lesbian, bisexual, and transgender populations. The Office of Prevention compared completed rates of suicide among these high-risk populations (specifically older adults and teens) to geographic distribution of prevention programs targeting risk factors for substance abuse that are also risk factors for suicide (for example, poor coping skills). Four counties appeared to be underserved by substance abuse prevention programs. Specifically, Apache, Navajo, Coconino and Cochise Counties had high rates of completed suicides among teens and few programs targeting risk factors for substance abuse and suicide. Counties with high rates of completed suicides among older adults and few prevention programs targeting this population included Mohave and Navajo Counties. ADHS/DBHS initiated meetings with the Navajo Nation to determine how to improve use of State prevention funds to address substance abuse outcomes through local prevention programs. Southeastern Arizona Behavioral Health Services partnered with CPSA to develop a youth leadership program for teens in Cochise and other southeastern counties. This program, Youth Educated for Success, involves teens learning about concepts related to resiliency and then developing action plans to improve the climates of their schools. NARBHA began to assess the quality of prevention programming in Mohave County to determine what changes if any should be made. All of the interventions described in the last several sentences were directly related to prevention of substance use among high risk populations in these counties.

Arizona's Governor identified child welfare issues as a priority for all human service activities in the state. Research indicated that approximately 80% of all children are removed from their homes due to abuse or neglect perpetrated by a substance-abusing parent or guardian. For this reason, ADHS looked at the prevalence of child abuse reports across the state as an indicator for substance use. These rates were examined in comparison to substance abuse prevention program location for the purpose of identifying counties that may be underserved by existing substance abuse prevention programs. Several counties were identified as needing more attention. Mohave, La Paz, and Cochise Counties appeared to have high prevalence of child abuse reports coupled with few prevention programs. The Office discussed these findings with the RBHA staff during monthly prevention coordinator meetings. Northern Arizona Regional Behavioral Health Authority (the RBHA for Mohave County) began assessing the quality of prevention programming in Mohave County to determine how improvements could be

made. The Community Partnership of Southern Arizona launched the Parent Resource Network in Cochise County. The Parent Resource Network is a coalition concerned with issues related to healthy parents and families. The Parent Resource Network completed a local assessment of community need for substance abuse prevention and developed a warm line for parents where parents can call in and talk to other parents when they have problems. The EXCEL Group conducted a community needs assessment and completed a draft logic model for creation of a substance abuse prevention program targeting La Paz County.

RBHA Level and Local Needs Assessment. CPSA completed a comprehensive needs assessment including review of social indicator data, Arizona Youth Survey data and results of community forums during 2003. Results of the needs assessment were used to establish three region-wide goals for all prevention funds: decrease laws and norms that promote behaviors which lead to substance abuse, increase family attachment, and increase sense of community. The goals were linked to a regional RFP to ensure provider focus on identified needs and intended outcomes for prevention services.

FY 2005 (PROGRESS):

OBJECTIVE: To use substance abuse treatment and prevention resources efficiently to meet established need and demand for services.

Treatment Capacity Assessment

ACTIVITIES:

- (1) Continue use of the Arizona Logic Model assessment process to support expansion of the provider network to deliver Covered Services to TXIX members and SAPT priority populations within required accessibility and quality standards.
- (2) Assess utilization of non-TXIX substance abuse resources to ensure availability of treatment to priority SAPT Block Grant populations.
- (3) Monitor RBHA implementation of FY 2005 SAPT Block Grant spending targets, in particular peer support and co-occurring disorders.

During FY 2005, ADHS/DBHS continued to use the Logic Model process to identify network gaps and establish priority development goals. In addition, BSAPT conducted a special review of treatment needs data related to methamphetamine, in order to develop a highly-focused best practice initiative during 2006. Finally, BSAPT participated in the Governor's Tribal Summit on Substance Abuse with a goal of enhanced partnerships with tribal nations to address methamphetamine and other substance abuse problems.

Statewide Findings of the FY 2005 Logic Model

- Improve services so they are more culturally and linguistically relevant to potential Hispanic/Latino clients as well as other residents of Arizona
- Continue development of peer-delivered support services for individuals with substance abuse disabilities

- Improve delivery of treatment to methamphetamine abusers
- Aid in improving care by developing and publishing performance improvement protocols
- Establish best practices group to identify and publish best practice methods in specific areas of clinical focus
- Continue collocation of substance abuse staff with agencies traditionally serving seriously mentally ill clients.
- Promote development of detoxification facilities in areas of the state where such service is not available.

Region-Specific Findings of the FY 2005 Logic Model

- Regions 2 and 4 (Cenpatico)
 - Need for increased housing options
 - Increase Peer Support Services
 - Increase Family Support Services
 - Increase staff capacity for service
 - Need for specialized treatment for methamphetamine abuse
- Regions 3 and 5 (CPSA)
 - Need to extend and enhance culturally and linguistically specialized services
 - Increased need for peer and family support services
- Region 1 (NARBHA)
 - Need to expand ability to provide services in additional languages
 - Need to develop and /or expand specialized services for substance abusing women with dependents in all sub-regions
 - Develop and expand social and medical detoxification services
 - Develop and expand peer and family support services
 - Need for more residential treatment capacity for adults and children in certain sub-regions
- Region 6 (ValueOptions)
 - Need for increased family and peer support
 - Need for expanded opioid treatment program capacity and additional facilities
 - Need for more collocation of substance abuse providers at seriously mentally ill treatment sites
 - Increase supported housing opportunities for women with dependents
 - Develop specialized treatment for methamphetamine abuse

Progress on State-Level Network Development Priorities– 2004-05

(See Goal #1 for additional detail)

- **Detoxification Continuum.** In response to trends identified in the Logic Model, the BSAPT prioritized enhancing the continuum of rural detoxification services during FY 2004 and 2005. The SSA participated in a legislatively established study committee on rural detoxification capacity and worked closely with NARBHA to address ongoing issues related to public inebriation in Flagstaff. BSAPT provided on-site technical consultation through an emergency medicine physician to medical staff in northern Arizona and continued to provide pressure and support to completion of the new Level 2 social detoxification facility in Benson (rural southeastern Arizona).

As of July 1, 2005, NARBHA remains under sanction for lack of accessible detoxification services and CPSA received a sanction warning for the Benson facility.

- **Peer Support Initiative.** Recruitment and deployment of peer consumers within substance abuse treatment agencies continued during 2005. BSAPT continued to work with technical consultants made available through CSAT TA to develop training curriculums for organizations interested in hiring peer workers. A dedicated training organization for substance abuse peer support will be launched through an RFP in the fall 2005. As of July 1, 2005, more than 85 peer staff were working in substance abuse outpatient, residential, detoxification and methadone treatment programs across the state. Fifteen agencies are now participating in this service expansion initiative.
- **Methamphetamine Centers for Excellence.** BSAPT worked closely with contractors to plan establishment of methamphetamine treatment centers in three regions (ValueOptions, CPSA, Gila River Indian Community). The centers will use evidence-based approaches for stimulant disorder treatment coupled with strategies with proven efficacy in improving engagement and retention in care (contingency management, motivational interviewing). All centers will become operational by December 2005. New services for methamphetamine users began operating in two regions under Cenpatco of Arizona on July 1, including special consultants for San Carlos Apache Tribe to address methamphetamine on native lands. BSAPT, in collaboration with the Pacific-Southwest ATTC, also designed and launched a first responder training program for tribal nations with two initial training events: Hopi Tribe (April 2005) and Navajo Nation (August 2005).
- **Adolescent/Young Adult Substance Abuse Services.** As an outcome of the special review of methamphetamine related data, BSAPT identified 16-24 year olds as a high-risk group within the treatment system. On August 1, BSAPT was awarded a CSAT Adolescent Treatment Coordination grant to expand availability of substance abuse education, early intervention and treatment services to this population.
- **Co-Occurring Disorder Expansion (Maricopa County).** Data from the Arizona Logic Model continued to point to needs for enhanced service availability for adults with serious mental illnesses and co-occurring substance use disorder. During 2005, BSAPT worked with ValueOptions to “co-locate” substance abuse treatment providers at clinic sites serving SMI adults. The “co-located” providers deliver immediate access to discovery, recovery and maintenance services in both group and individual venues, as well as providing specialized consultations to psychiatrists and case management staff at the sites. As of July 1, co-located providers were located at 15 clinic sites in Maricopa county.

Prevention Needs Assessment

ACTIVITIES:

- (1) Monitor RBHA use of needs assessment data in local proposals for funding.
- (2) Monitor prevention program correlation with community need through the annual Evaluation Report.

State-Level Needs Assessment. Office of Prevention representatives began

participation in the statewide epidemiological workgroup established under the SPF-SIG grant awarded in the fall 2004. The grant is managed by Governor's Division for Substance Abuse Policy and includes representation from the Arizona Criminal Justice Commission, Department of Economic Security, Department of Education, Administrative Office of the Courts, Arizona Prevention Resource Center, and provider agencies. The group began development of a model for epidemiological assessment of the prevalence and extent of substance abuse problems and key consequences in Arizona. Initial data collection included information on prevalence of substance use and substance related problems at the state and regional level. The Epidemiology Work Group will use the data model to establish priorities for a State Strategic Prevention Plan, which will be developed in coordination with the Strategic Prevention Framework/ State Incentive Grant advisory board. As of July 1, the group had established inappropriate or illegal use of alcohol as a state priority and is considering how to incorporate a priority related to use of illegal substances.

Key findings from the Epidemiology Workgroup (Excerpts from the Summary Report prepared by the Governors Division of Substance Abuse Policy)

1. Eighteen to twenty-five year olds have the highest rates of use for all substances and the highest rates for alcohol or illicit drug dependence or abuse.
2. Twelfth grade has the highest percentage of students that have used alcohol (51.1 percent), tobacco (24.4 percent), and illicit drugs (25.1 percent) in the past 30 days or have engaged in binge drinking in the past two weeks (32.4 percent). Eighth grade students report substantial amounts of substance use in the past 30 days (25 percent have used alcohol and 18 percent have used an illicit drug).
3. Highest rates for a majority of the problem indicators such as substance consumption, drug-related arrests, and alcohol related car crashes, cluster in the 18 to 25 year age group.
4. Cochise, Gila, Mohave, and Santa Cruz counties have the most problems with youth using alcohol in the past 30 days, and past two-week youth binge drinking.
5. Within Cochise and Gila counties the Douglas and Globe/Hayden health analysis areas have higher than average percentages of youth that report binge drinking and past 30-day alcohol use. Within Cochise and Coconino counties, the Benson and Williams health analysis areas report higher than average youth binge drinking rates. Within Mohave county, the Kingman and Lake Havasu City health analysis areas have higher than average percentages of past 30-day youth alcohol use.
6. Apache, Graham, Coconino, and Navajo counties have the most problems with illicit drug use among 8th, 10th, and 12th grade students. For past month drug use among 8th through 12th grade students, the health analysis areas of Page/Fredonia, Flagstaff West, Flagstaff East, Flagstaff Rural, Winslow, Holbrook, Benson, Navajo Nation, Hopi Nation and Havasupai Tribe have higher than average percentages of drug use.

These key findings generally corroborated examination of county regional data pertaining to severe outcomes of substance abuse such as child abuse and suicide.

Results of the 2004 Arizona Youth Survey were distributed to providers, Tribal contractors, and T/RBHAs via the prevention list serve. The Office conducted a workshop for providers regarding how to use the Arizona Youth Survey data in

combination with other needs assessment data to establish target populations and program goals at the annual Prevention Provider Meeting held in June 2005.

New guidelines and requirements for T/RBHA needs assessments were outlined in the 2005 'Framework for Prevention in Behavioral Health'. The new guidelines require T/RBHAs to complete a formal, comprehensive assessment of regional needs and resources on a regular basis at least once every three years or prior to issuing a new region-wide prevention request for proposals. The assessment must be timed so results can shape the RFP. A written summary of the comprehensive assessment will be forwarded to ADHS in the annual end-of-the-year report.

Substance use related outcomes. The Arizona Department of Health Services is continuing to monitor other indicators of substance use including suicide and child abuse. The suicide mortality rate is chronically higher in Arizona compared to the United States. The 2004 Arizona Youth Survey demonstrated a strong link between students who report depressive symptoms and alcohol, tobacco, and other drug use. When compared to the non-depressed group, depressed youth are nearly three times as likely to use cigarettes in the 30 days prior to the survey, over two times as likely to use marijuana in the past 30 days, and over three times as likely to have used any drug in the past 30 days. Suicide prevalence correlates highly with substance abuse and is a good indicator of populations with high need for substance abuse prevention. The 2004 survey also showed an increase across all grades for depressive symptoms compared to 2002.

The BSATP hired a Suicide Prevention Coordinator in January 2004 to improve the Department's approach to prevention of substance abuse related suicide. This position involves substantial work related to substance abuse prevention.

The BSATP conducted a statewide survey/needs assessment of substance abuse prevalence and suicide as an indicator of prevalence. Results of the survey indicated a need for increased training to raise awareness of community resources for behavioral health problems. First responders, school staff, and law enforcement lack knowledge of available resources and the confidence to make appropriate referrals. Considerable interest was expressed by providers in receiving training on best practice models of substance abuse and suicide prevention, especially best practices utilizing gatekeeper-training strategies. Culturally relevant and adaptable programs were rated as an area of high need, especially for Spanish-speaking and Native American youth.

Regional Needs Assessment. The Maricopa County RBHA, ValueOptions, collected social indicator data and used Geographic Information Systems (GIS) technology to create maps showing rates of substance abuse and substance abuse-related problems across Maricopa County. Based on analysis of this information, Value Options selected zip code areas with the highest prevalence of risk indicators for targeting of prevention programs. ValueOptions issued a new RFP for funding in the spring of 2005. Providers selected to provide services were required to provide results from a recent needs assessment including analysis of data and input from target participants. Providers whose chosen service area fell outside of the designated high risk zip code areas identified by ValueOptions, had to justify selection of their community using their own needs assessment data.

The newest RBHA, Cenpatco of Arizona, which covers Gila, La Paz, Pinal, and

Yuma Counties, conducted a region-wide needs assessment incorporating social indicator data and information from community forums. Information from this assessment was used to determine the type of programming Cenpatico would purchase. Cenpatico initiated contracts with providers formerly contracted with Pinal Gila Behavioral Health Association and the EXCEL Group for services that were consistent with the results of the needs assessment. Cenpatico will issue Letters of Intent during the early part of fall of 2005 and award new contracts that will begin October 1, 2005.

CPSA conducted an assessment of needs and resources related to behavioral health of older adults and risk factors related to substance abuse. The assessment included a series of focus groups and interviews with older adults to determine most appropriate means for distribution of information for a social marketing campaign. Results indicated older adults in Pima County are at elevated risk for suicide due to isolation, medication changes, and financial difficulties. Participants in the study were unaware of any suicide prevention programs targeting older adults.

FY 2006 (INTENDED USE):

OBJECTIVE: To use substance abuse treatment and prevention resources efficiently to meet established need and demand for services.

Treatment Capacity Assessment

ACTIVITIES:

- (1) Continue use of the Arizona Logic Model assessment process to support expansion of the provider network to deliver Covered Services to TXIX members and SAPT priority populations within required accessibility and quality standards.
- (2) Assess utilization of non-TXIX substance abuse resources to ensure availability of treatment to priority SAPT Block Grant populations.
- (3) Monitor RBHA implementation of FY 2005 and 2006 SAPT Block Grant spending targets, in particular peer support, detoxification and methamphetamine.

Prevention Services

ACTIVITIES:

- (1) Continue participation in the State Epidemiology Work Group and use findings to determine how best to advance SAPT-funded prevention programs.
- (2) Monitor requirements related to RBHA implementation and application of community needs assessment.
- (3) Provide assistance to the Arizona Criminal Justice Commission in recruiting schools for the 2006 Arizona Youth Survey.
- (4) Develop standard training for providers in needs assessment and provide training as requested.

GOAL # 14.-- An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FY 2003 (COMPLIANCE):

ACTIVITIES:

- (1) Ensure inclusion of prohibition in all contract and regulatory documents.

COMPLIANCE:

- (1) **Contracts/Policy.** The prohibition on use of Block Grant funds for purchasing hypodermic needles was cited in the RBHA contracts and ADHS/DBHS Provider Manual during 2003. Language containing this restriction was also included in the Request for Proposals for Maricopa County, which was released in September 2003.

FY 2005 (PROGRESS):

- (1) **Contracts/Policy:** Each RBHA and the Gila River Indian Community have their contract in force through FY 2005. The contracts continued the prohibition against the use of Block Grant funds for purchasing hypodermic needles for distribution to individuals who may use them to inject illegal drugs.

FY 2006 (INTENDED USE):

ACTIVITIES:

- (1) Ensure inclusion of prohibition in all contract and regulatory documents.

GOAL # 15.

An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FY 2003 (COMPLIANCE):

OBJECTIVE: Establish an independent peer review process as one aspect of quality control of treatment procedures.

ACTIVITIES:

- (1) Utilize results of prior year IQE/peer reviews to improve and develop treatment systems.
- (2) Contract with an independent consultant to conduct the 2003 Independent Case Review of not less than 5% of contracted substance abuse providers.

COMPLIANCE:

The ADHS/DBHS continued to contract with Health Systems Advisory Group to conduct the 2003 Case Review. This study involved a random sample of 1,540 medical records assessed across 21 standards. A specific subset of standards identifying injection drug abusers and pregnant women in the sample allowed for review of quality findings specific to those SAPT priority populations. Key areas for review included: access to care, coordination of care with medical services, sufficiency of assessment, individual and family involvement, cultural competency and quality clinical outcomes. Overall, 50% of all standards were met or exceeded for adults and 75% were met for children enrolled in behavioral health services. Findings for the subset targeting pregnant women and injection drug abusers indicated that between 55-60% of the minimum performance standards were met for these populations.

Case Review results that highlighted opportunities to improve were presented and discussed in a technical assistance meeting held in August 2003 which brought together RBHA directors, quality management directors, medical and clinical directors, and program staff to develop state-driven and local performance improvement plans. The ADHS/DBHS prioritized three key areas for improvement: (1) cultural competence, (2) informed consent when medication is indicated, and (3) coordination of treatment with primary care physicians. These areas were incorporated into DBHS strategic improvement activities throughout 2004. A DBHS Cultural Competence Committee was formed that is considering effective methods of enhancing treatment by ensuring a person's values, heritage and background are considered in treatment planning. The DBHS Medical Director developed a standard consent form for psychotropic (includes substance abuse treatment-related medication) medication use, and a standardized movement disorder scale plus a training package to use with it. The Medical Director also developed a standardized primary care physician coordination form which indicates when communication between doctors should be initiated and what types of information should be shared.

The RBHA plans incorporated activities to implement the three ADHS/DBHS performance targets as well as any other standards where performance did not achieve the 85% threshold. RBHAs submitted quarterly updates of their progress in implementing the plan.

FY 2005 (PROGRESS):

OBJECTIVE: Establish an independent peer review process as one aspect of quality control of treatment procedures.

ACTIVITIES:

- (1) Utilize results of prior year Independent Case Reviews to improve and develop treatment systems.
- (2) Contract with an independent consultant to conduct the 2005 Independent Case Review.

PROGRESS:

The FY 2005 Independent Case Review (ICR) was conducted using a statewide sample of both Title XIX and Title XXI adults and children members who met the following selection criteria:

- Members were identified as behavioral health recipients for at least 90 continuous days in the six months prior to January 1, 2005 (the date for the implementation of the review);
- Members who received only transportation, laboratory, radiology/medical imaging, and/or crisis services were excluded.

Forty-four adult substance abusers that injected drugs, some of which also abused other drugs, were included in the sample. This selection was scattered across 6 State Regions and one Tribal area.

The study period was April 1 through December 31, 2004. However, client records were scanned to include all pertinent information from January 1, 2004 through December 31, 2004. Health Systems Research Group was again contracted to conduct the review.

The sample was statistically valid for each geographic service area with 90% confidence level and a confidence interval of +/- 5%. The sample for a given geographic service area was drawn from children and adults proportionate to the percent of the total number of behavioral health recipients in the geographic service area represented by each. The sample was selected at random. In addition to the TXIX/TXXI sample cases for each geographic service area, a total of 90 Tribal RBHA cases and 350 Developmentally Disabled (DD) cases statewide were included in the review. Sampling followed the same selection criteria explained above and was drawn proportionate to the percent of the total number of behavioral health recipients in the region.

Initial findings of the ICR indicate significant improvements across all standards and in all regions. Areas identified for continued focus include: 1) assessment of cultural preferences 2) providing informed medication consent using the standardized tool and 3)

outreach and re-engagement after missed appointments. The final ICR report will be published in October 2005.

A special study (addendum) will be conducted on TXIX/XXI children receiving behavioral health services in Maricopa County and identified to have a Child and Family Team. This study will involve both record review and interview. The interview portion of the study will consist of three types of informants: (a) client or family/guardian, (b) case manager/team facilitator, and (c) outpatient provider. A total of 30 cases will be selected from this geographic service area ICR sample population. Only cases identified to have a Child and Family Team will be included in the study.

FY 2006 (INTENDED USE):

OBJECTIVE: Establish an independent case review process as one aspect of quality control of treatment procedures.

ACTIVITIES:

- (1) Utilize results of the 2005 Independent Case Review to improve and develop treatment systems.
- (2) Contract with an independent consultant to conduct the 2006 Independent Case Review.

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))

For the fiscal year two years prior (FY 2004) to the fiscal year for which the State is applying for funds:

In up to three pages provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2004 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of procedures may include, but not be limited to:

- the role of the single State authority (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;
- the role of the State Medical Director for Substance Abuse Services in the development of such procedures;
- the role of the independent peer reviewers; and
- the role of the entity(ies) reviewed.

Examples of activities may include, but not be limited to:

- the number of entities reviewed during the applicable fiscal year;
- technical assistance made available to the entity(ies) reviewed; and
- technical assistance made available to the reviewers, if applicable.

PROCEDURES:

The ADHS/DBHS Division of Quality Management under the oversight of the ADHS/DBHS Medical Director conducts the annual Independent Case Review. Clinical Bureaus, including the BSATP, are involved in selection of case review standards and operational implementation of corrective action plans resulting from sub-standard performance. The Quality Management Division selects the random sample of records for review using ADHS/DBHS enrollment data and coordinates acquisition of case records by the RBHAs.

Health Systems Advisory Group (HSAG) has served as the independent review organization under contract with ADHS/DBHS for the past four years. This organization uses a team of physicians, clinicians and health care providers to abstract charts using a standardized tool and instructions developed in consultation with DBHS. Arizona Health Care Cost Containment System, the state's Medicaid agency, also reviews the tool. HSAG also prepares the final report and technical assistance recommendations.

The role of the RBHA is to provide a complete medical record for each identified patient.

ACTIVITIES:

For FY 2004, more than 1,500 medical records were abstracted and reviewed. HSAG trained a team of multi-disciplinary reviewers to abstract data efficiently, accurately and reliably. Inter-rater reliability was tested and achieved 95% by the time training was completed.

The comparison of findings of the FY 2003 and FY 2004 Independent Case Reviews demonstrated that both adults and children receiving services in the public behavioral health system demonstrated improvements in both symptoms and level of functioning. Specific areas of improvement included engagement of family members in the treatment planning process for the adult population, client outcomes and comprehensiveness of assessment. In general, the standards that met or exceeded the minimum performance score for 2004 also met or exceeded the requirements for 2003, demonstrating a pattern of continued compliance.

Five areas did not meet the minimum performance scores and subsequently were the focus of performance improvement initiatives. These were:

- Outreach and follow-up after missed appointments.
- Assessment of cultural preferences and incorporation into the treatment plan
- Informed consent
- Documentation of specific target symptoms for each prescribed medication
- Documentation of annual lithium blood levels for individuals prescribed lithium carbonate.

A comparison of results from 2003 to 2004 indicates that improvements have been made in the scores for standards related to cultural preferences, informed consent, documentation of specific target symptoms for each medication, and documentation of annual lithium levels for individuals prescribed lithium carbonate. However, these standards still did not meet the minimum thresholds for 2004 and continued to be a focus for performance improvement. Significantly, the score for the standard measuring outreach and follow-up experienced a decline for 2004 when compared to 2003, with follow-up after missed appointments identified as the outlier element.

ADHS/DBHS uses a systematic process for assessing performance improvements in follow-up to the annual ICR. A technical assistance meeting is conducted following release of the study and including both medical, program and executive representation from the RBHAs and DBHS. Following the meeting, specific plans of correction are required with quarterly progress updates. Re-measure in a subsequent ICR is the yardstick for assessing improvement. This process will be implemented upon release of the final ICR 2004 report.

Specific follow-up to major 2003 performance trends common to all RBHAs included:

- **Assessment of cultural preferences:** A self-assessment of cultural competency activities was conducted using an instrument developed by the National Association of State Mental Health Program Directors (NASMHPD) to identify areas of training needed by the behavioral health community. Results from the tool were used to update the ADHS/DBHS Cultural Competency Plan. ADHS/DBHS worked with the Center for Substance Abuse Treatment (CSAT) and consultants to develop a standardized self-assessment tool for the Tribal and

Regional Behavioral Health Authorities (T/RBHAs) to use in assessing cultural competency of their organizational structures and to determine the impact of assessing cultural competency on the behavioral health service delivery. ADHS/DBHS revised its Provider Manual section regarding cultural competency to include specific requirements in the area of culturally and linguistically appropriate services (CLAS). RBHAs also developed specific training programs to improve assessment processes for cultural preferences.

- **Informed consent:** The ADHS/DBHS Medical Director developed an Informed Consent Performance Improvement Protocol (PIP) including a standardized medications consent form and specific procedures. T/RBHAs were required to implement the interventions identified by the PIP work group in order to improve performance with the informed consent requirements. T/RBHA monitoring activities included chart reviews to identify prescribers who do not comply with this standard.
- **Documentation of specific target symptoms for each prescribed medication:** ADHS/DBHS developed a PIP designed to improve the quality of documentation when multiple medications are prescribed to treat a condition. Data from the 2003 and 2004 ICR were used to establish a baseline for the project and a work group consisting of RBHA Medical Directors was formed to identify and implement measures to improve performance in this area.
- **Outreach and follow-up:** The 2004 findings for outreach and follow-up in response to adverse clinical events is a roll-up standard measuring performance following missed appointments, service refusal, crisis events and discharge from inpatient and Level 1 settings. All T/RBHAs developed and implemented corrective action plans to address individual issues in this area. Preliminary 2004 data indicates improvements in all areas except follow-up after missed appointment.
- **Documentation of annual lithium levels:** This issue was brought forward to the RBHA Medical Directors for resolution.

GOAL # 16.--An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. part 2).

FY 2003 (COMPLIANCE)

OBJECTIVE: Ensure that patient-identifying information is maintained in a confidential manner pursuant to federal and state law.

ACTIVITIES:

- (1) Continue implementation of Health Insurance Portability and Accountability Act (HIPAA) privacy regulations and ensured incorporation into contract and policy.
- (2) Implement model information sharing protocol for families involved in child protective services and substance abuse treatment.

COMPLIANCE:

- (1) **Contract/Policy.** On April 14, 2003, the Division completed all training on HIPAA privacy regulations and initiated the implementation plan for RBHA and provider compliance with HIPAA regulations. The Division monitored RBHA compliance with HIPAA regulations during the 2003 annual Administrative Reviews, which began in August. The DBHS Policy Office reviewed and approved each RBHA's confidentiality policy to ensure compliance with 42 CFR 2. Privacy requirements were detailed in the RBHA contract and the ADHS/DBHS Provider Manual published in September 2003.

For purposes of HIPAA implementation, the state of Arizona was designated the "covered entity" under which individual state agencies identified themselves as "health care providers" as appropriate to their scope of service. Within the ADHS/DBHS regional system, RBHAs and provider organizations are separate health care providers with requirements to establish, maintain and oversee their individual plans for HIPAA compliance. The ADHS established a HIPAA Privacy Officer at both the Division and Department level.

- (2) **Quality Improvement.** The Intergovernmental Agreement between Arizona Department of Economic Security and ADHS for the Joint Substance Abuse Treatment Fund continued in effect. The agreement required the agencies to jointly establish a protocol for confidentiality and information sharing related to substance abuse patients with children involved in child protective services. A number of considerations were noted in the development of guidelines for information sharing across systems including: federal laws regarding substance abuse treatment confidentiality, needs of child welfare caseworkers and the courts, and state law on confidentiality in child abuse/neglect reporting. The final protocol placed responsibility for adherence to confidentiality laws and requirements under the auspices of the contracting state agency.

FY 2005 (PROGRESS)

OBJECTIVE: Ensure that patient-identifying information is maintained in a confidential manner pursuant to federal and state law.

ACTIVITIES:

- (1) Conduct annual review of RBHA contracts to ensure inclusion of language relevant to 42 CFR 2 and HIPAA.
- (2) Provide technical assistance as needed to RBHAs and providers relevant to sharing information on patients in substance abuse treatment.
- (3) Implement the Technical Assistance Document on “Information-Sharing with Family Members of Adult Consumers.”

PROGRESS:

- (1) **Contracts/Policy.** RBHA contracts were reviewed as part of the annual amendment process in the spring 2005 to ensure continuation of requirements on patient confidentiality. The requirements were also incorporated into the Request for Proposals for Greater Arizona awarded for July 1, 2005.

The Department and the Division of Behavioral Health continued to maintain HIPAA Privacy Officers with responsibility to monitor complaints related to violations of privacy regulations and to offer technical assistance as needed to RBHAs and providers.

- (2) **Quality Improvement.** The ADHS/DBHS Technical Assistance Document “Information Sharing with Family Members of Adult Consumers” was finalized and published in the spring 2005. The document provides guidelines for analyzing situations in which information may or may not be shared and the specific limits on allowable information sharing to include HIV and substance abuse treatment information without signed consent.

FFY 2006 (INTENDED USE):

OBJECTIVE: Ensure that patient-identifying information is maintained in a confidential manner pursuant to federal and state law.

- (1) The ADHS/DBHS will continue to maintain a Privacy Officer within the Division and the Department.
- (2) Continue to monitor complaints related to violations of 42 CFR 2 in the problem resolution system and interactions with the ADHS and DBHS Privacy Officers.

GOAL #17.--An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provisions and Regulations.

FY 2003 (COMPLIANCE):

Not Applicable

FY 2005 (PROGRESS):

OBJECTIVE: To implement charitable choice requirements for persons receiving substance abuse services funded through the SAPT Block Grant.

ACTIVITIES:

- (1) Develop and implement a process for notification of recipients.
- (2) Provide technical assistance to RBHA-funded agencies and other community providers.

PROGRESS:

- (1) **Contracts/Policy.** The ADHS/DBHS conducted a review of U.S.C. 300x-65 and 42 CFR Part 54 in the fall 2003 to determine the scope of the statute and regulation and to clarify requirements under provisions for “co-mingling” of funds. The review was conducted jointly between the BSATP, the ADHS/DBHS Policy Office and the Arizona Attorney General’s Office. Based upon the review, the ADHS/DBHS developed contract language that prohibited the RBHAs from discriminating against religious organizations in contracting SAPT Block Grant funds and established a requirement for notification of recipients of their right to receive services from an alternative provider. The process was detailed in an update of the ADHS/DBHS Provider Manual published July 2004 and included the model notice to recipients in 42 CFR Part 54.
- (2) **Quality Improvement/Technical Assistance.** The BSATP Chief discussed the regulations and notification and referral process with the RBHA Substance Abuse Coordinators at both the March and June 2004 quarterly meetings. Additional technical assistance was provided at the September 2004 RBHA Substance Abuse Coordinators meeting to address questions surrounding referral requirements.

FY 2006 (INTENDED USE):

ACTIVITIES:

- (1) Ensure contract and Provider Manual continue to contain requirements related to non-discrimination and alternative provider referrals.
- (2) Provide technical assistance to RBHA-funded agencies and other community providers as needed.

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are

providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

State:
Arizona

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- ☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d))
- ☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))
- ☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))
- ☐ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))
- ☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as Attachment J to the application. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively.

Description of Calculations

In a brief narrative, provide a description of the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

(a) Calculations for the base for services to pregnant women and women with dependent children are required by section 1922(c)(1), and are provided as follows:

Calculations for the base year are grounded in a survey done in FY 92 attempting to capture all specialty women's treatment programs operating during that year.

Programs dealing with single women were removed in order to develop these calculations. Most calculations suffer from a duplicative effect in the computer report that drives the overall base value for FY 92 higher than actual.

The total value of services to pregnant women, and women with dependent children who received primarily residential treatment services in SFY 92 at state supported treatment programs equaled \$1,225,977. In the base year, \$1,164,678 was estimated from Block Grant, with \$61,299 from State appropriations. Current maintenance information can be found in Section II, Table IV (MAINTENANCE, MOE Tables section).

(b) Calculations for the base and Maintenance Of Effort for tuberculosis services as required by Section 1924(d) are provided as follows:

The Department of Health Services has a functional unit called Infectious Disease Services. Their expenditures for TB services were discussed with a staff member in the Tuberculosis Control section. No specific funds are spent by Infectious Disease Services for substance abusers who need T.B. services. There are contracts with all County health departments (except Apache County) as well as the Navajo and Tohono O'Odham Tribes. The amounts spent from State funds for SFY 91, 92, and 93 are portrayed in the following table.

DHS State Expenditures for TB Control

	<u>FY 90/91</u>	<u>FY 91/92</u>	<u>FY 92/93</u>
Extramural	850,111	805,802	822,490
Intramural	66,543	54,915	54,035
Total	\$916,654	\$860,717	\$876,525

7.89% of the cases reported are known drug abusers. Using that rate as a crude delineation of funds spent for substance abuse related TB services (e.g., $916,654 + 860,717 = 1,777,371$) $2 = 888,685 \times 7.89\% = 70,117$) gives \$70,117 as the DHS share. {While 7.89% was the rate used in response to the 94 Terms and Conditions, it was derived from a partial years (9 months) figures. A full 12 month rate dropped to 3.48%. Additional information from the Office of Infectious Disease Control/TB Elimination Section, providing injection substance abusers in treatment data, further reduces State funds spent on substance abusers with TB in substance abuse treatment}. Additional information can be found in Section II, Table II (BASE AND MAINTENANCE, MOE Tables section). The footnote for that Table also provides relevant information.

(c) Calculations, for designated states, for the base and MOE for HIV early intervention services as required under 1924(d) and 45C.F.R. 96.122(f)(5)(ii)(A)(B)(C) are provided as follows:

Arizona became a designated state for the first time during the preparation of the 1994 SAPT Block Grant application. The Arizona Department of Health Services (ADHS) has an Office of HIV/STD Services within the Bureau of Epidemiology and Disease Control. This Office manages ADHS responsibilities for HIV/AIDS efforts, primarily through subcontracts with county public health departments. The Office does not maintain FTE staff with responsibility for conducting "HIV early intervention services" as defined at 1924(b)(7)(B). The Office manages contracts with community agencies for testing and pre- and post-counseling as well as funding for the provision of "therapeutic measures". However, the funds used to support those services have been exclusively from non-state sources.

In SFY 1998, the Arizona State Legislature provided an emergency, one-time appropriation of up to \$930,000 from tobacco assessment revenues to insure continuation of the availability of AIDS medications following a reduction in federal revenues. For SFY 1999, the Legislature appropriated \$1.7 million from tobacco assessment revenues, identified as one-time funds for AIDS medication. Again, for SFY 2000, 2001, 2002, and 2003 the legislature identified one-time-only medication funding of \$1 million for each year. In 2004 and again in 2005, the Governor's Office arranged for like funding to continue. Neither legislation, nor Governor's allocation, of the one-time funding contained a particular stipulation regarding drug or alcohol abusers. Therefore, as best can be determined, the Arizona Department of Health Services does not spend state appropriated funds on HIV/AIDS early intervention services as defined in the Block Grant legislation.

In years when Arizona was not a designated state for HIV early intervention service requirements, the ADHS/DBHS elected to continue providing pre- and post-test counseling, HIV testing and HIV case management service for substance abusers in treatment and through HIV drop-in centers and IDU street outreach programs. For the FFY 2006 SAPT Block Grant application, Arizona was notified (by CSAT) it is a designated state.

1. Planning

For the planning narrative please see Goal 1.

How your State determined the numbers for the matrix

States are required to utilize data from CSAT or CSAP needs assessment contracts. If your State did not use this data, using up to three pages, explain what methods your State uses to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources of data used in making these estimates. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7.

How Arizona determined the numbers for the matrix:

The projected number of people in Arizona who need and/or would seek treatment was derived from the Arizona Substance Abuse Needs Assessment Telephone Household Study. This study is part of Arizona's "family of studies" funded in October 1994 by the Center for Substance Abuse Treatment. The telephone survey is the largest of the "family of studies" and was the first to be completed. The purpose of the study was to determine the prevalence of clinical levels of substance abuse and dependence for non-reservation adults age 18-64. (Adult reservation members were surveyed in a separate study). Over 8,500 adults across the State were sampled using a random digit dialing procedure. Assessments were based on the Diagnostic Interview Schedule (DIS) using DSM III-R criteria for substance abuse and dependence. Individuals were randomly selected to participate using the "most recent birthday" method. The distribution of the statewide sample was determined through optimal allocation procedures employing estimates of heroin prevalence. Moreover, a minimum sample of 1,000 respondents was established for each sub-state planning area. The sample was truncated at age 65, since Arizona's popularity as a retirement state artificially increases the proportion of elderly. This elderly population is predominantly female, has a low prevalence of drug/alcohol abuse, and rarely uses state-supported treatment services. A minimum of ten calls was made to each household and up to eight call-backs was made to complete interviews once the respondent was identified. The response rate was 66%. Fifteen percent of the sample originally refused to participate and was then converted. The National Technical Center (NTC) Substance Dependence Needs Assessment Telephone Survey (V 6.33) was the measure employed for this study. Individuals who met the screening criteria were asked the DIS items and were also questioned about treatment history, unmet need, and barriers to care. Individuals not meeting the screening criteria were asked basic demographic questions before the interview was terminated.

Limitations:

While this survey provides useful information for block grant planning it does have several limitations. This survey sampled only non-reservation adults: thus, all projections are restricted to this sub-population. The Tribal Substance Abuse Needs Assessment Study provided prevalence rates for Native Americans living on reservations. Adolescent estimates are limited to juveniles booked in detention facilities. In addition, the survey reached only those individuals who live in households with phones. The exclusion of homeless persons and individuals without phones likely results in an under-estimation of need since those populations tend to have higher than average rates of substance abuse problems. Furthermore, we have no information about the individuals who refused to participate. Thus, we cannot determine whether those who

participated differed from those who refused. During the development of this instrument, the American Psychiatric Association updated the Diagnostic and Statistical Manual. We now use the DSM-IV rather than the DSM III-R. In addition, our current projection of need is based on population denominators that are based on 2002 Census projections. Finally, the survey used to estimate treatment need was conducted in 1996 and may not be fully representative of the Arizona population as a result of in- and out-migrations.

Form 8

The columns for Form 8 are defined as follows:

The 2004 population estimates were used as the population base. The population estimate includes age, gender and ethnicity data. The sample did not go beyond age 65; all other particulars applicable to the 1996 survey data was also applied to the current process.

Column 3A: The number of individuals meeting DSM IV-R criteria for lifetime substance abuse or dependence defines the need for treatment.

Column 3B: Those who would seek treatment are individuals who had sought treatment in the past 12 months.

Column 4A: Injection drug users are those who injected drugs within the last 18 months.

Column 4B: Injection drug users who would seek treatment are those who had sought treatment in the past 12 months.

Column 5A: Women meeting DSM IV-R criteria for current substance abuse or dependence.

Column 5B: Women who would seek treatment are those that had sought treatment in the past 12 months.

Column 6A: The number of DWI arrests and drug-related arrests were taken from the Arizona Uniform Crime Report (2003).

Column 6B: Drug related arrests include only those for drug possession (2003).

Column 6C: The Other category comes from the number of drug sales/manufacturing (2003).

Columns 7A-C: Taken from Arizona Vital Statistics (2003) as well as HIV website. AIDS mean figures now provided in a five year aggregate (dividing by 5 provided an estimate of a one year mean).

Form 9

Columns (B-H) present race regardless of Hispanic origin, and sum to Column A; Columns I and J also sum to Column A.

Note: All clients who said they are Hispanic but could not be identified by race were assumed to be White.

ANNUAL SYNAR REPORT

42 U.S.C. 300x-26

OMB ? 0930-0222

Arizona

FFY 2006



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

Table of Contents

Introduction.....	ii
Funding Agreements/Certifications	1
Section I: FFY 2005 (Compliance Progress)	2
Section II: FFY 2006 (Intended Use).....	8
Appendix A: Forms.....	10
Appendix B: Synar Survey Sampling Methodology	18
Appendix C: Synar Survey Inspection Protocol	21
Appendix D: List Sampling Frame Coverage Study	23

INTRODUCTION

The Annual Synar Report (ASR) format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 U.S.C. 300x-26) and the Tobacco Regulation for the SAPT Block Grant (45 C.F.R. 96.130 (e)).

An agency may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0222 with an expiration date of 08/31/2007. Public reporting burden for the collection of information is estimated to average 15 hours for Section I and 3 hours for Section II, including the time for reviewing instructions, completing and reviewing the collection of information, searching existing data sources, and gathering and maintaining the data needed. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0222); 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland 20857

How the Synar report helps the Center for Substance Abuse Prevention

In accordance with the tobacco regulations, States are required to provide detailed information on progress made in enforcing youth tobacco access laws (FFY 2005 Compliance Progress) and future plans to ensure compliance with the Synar requirements to reduce youth tobacco access rates (FFY 2006 Intended Use Plan). These data are required by 42 U.S.C. 300x-26 and will be used by the Secretary to evaluate State compliance with the statute. Part of the mission of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) is to assist States¹ by supporting Synar activities and providing technical assistance helpful in determining the type of enforcement measures and control strategies that are most effective. This information is helpful to SAMHSA/CSAP in improving technical assistance resources and expertise on enforcement efforts and tobacco control program support activities, including State Synar Program support services, through an enhanced technical assistance program involving conferences and workshops, development of training materials and guidance documents, and on-site technical assistance consultation.

How the Synar report can help States

The information gathered for the Synar report can help States describe and analyze sub-State needs for program enhancements. These data can also be used to report to the State legislature and other State and local organizations on progress made to date in enforcing youth tobacco access laws when aggregated statistical data from State Synar reports can demonstrate to the Secretary the national progress in reducing youth tobacco access problems. This information will also provide Congress with a better understanding of State progress in implementing Synar, including State difficulties and successes in enforcing retailer compliance with youth tobacco access laws.

¹The term State is used to refer to all the States and territories required to comply with Synar as part of the Substance Abuse Prevention and Treatment Block Grant Program requirements (42 U.S.C. 300x-64 and 45 C.F.R. 96.121).

Getting assistance in completing the Synar report

If you have questions about programmatic issues, you may call CSAP's Division of State and Community Assistance at 240-276-2570 and ask for your respective State Project Officer, or contact your State Project Officer directly by telephone or e-mail using the directory provided. If you have questions about fiscal or grants management issues, you may call the Grants Management Officer, Office of Program Services, Division of Grants Management, at 240-276-1404.

Where and when to submit the Annual Synar Report

The Annual Synar Report (ASR) must be received by SAMHSA no later than December 31, 2005. The ASR must be submitted in the **approved OMB report format**. Use of the approved format will avoid delays in the review and approval process. The chief executive officer (or an authorized designee) of the applicant organization must sign page 1 of the ASR certifying that the State has complied with all reporting requirements.

Submit one signed original of the report, one additional copy, and an electronic version on either CD-ROM or 3.5" diskette to the Grants Management Officer at the address below:

Grants Management Officer
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration

Regular Mail:

1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

Overnight Mail:

1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20850

FFY 2006: FUNDING AGREEMENTS/CERTIFICATIONS

The following form must be signed by the Chief Executive Officer or an authorized designee and submitted with this application. Documentation authorizing a designee must be attached to the application.

PUBLIC HEALTH SERVICES ACT AND SYNAR AMMENDMENT
42 U.S.C. 300x-26 requires each State to submit an annual report of its progress in meeting the requirements of the Synar Amendment and its implementing regulation (45 C.F.R. 96.130) to the Secretary of the Department of Health and Human Services. By signing below, the chief executive officer (or an authorized designee) of the applicant organization certifies that the State has complied with these reporting requirements and the certifications as set forth below.
SYNAR SURVEY SAMPLING METHODOLOGY
The State certifies that the Synar survey sampling methodology on file with the Center for Substance Abuse Prevention and submitted with the Annual Synar Report for FFY 2006 is up-to-date and approved by the Center for Substance Abuse Prevention.
SYNAR SURVEY INSPECTION PROTOCOL
The State certifies that the Synar Survey Inspection Protocol on file with the Center for Substance Abuse Prevention and submitted with the Annual Synar Report for FFY 2006 is up-to-date and approved by the Center for Substance Abuse Prevention.
State: _____
Name of Chief Executive Officer or Designee: _____
Signature of CEO or Designee: _____
Title: _____ Date Signed: _____
If signed by a designee, a copy of the designation must be attached

SECTION I: FFY 2005 (Compliance Progress)**YOUTH ACCESS LAWS, ACTIVITIES, AND ENFORCEMENT**

42 U.S.C. 300x-26 requires the States to report information regarding the sale/distribution of tobacco products to individuals under age 18.

- 1. Please indicate any changes or additions to the State tobacco statute(s) relating to youth access since the last reporting year. Please attach a photocopy of the change(s) in the State law(s) if any was made since the last reporting year. (See 42 U.S.C. 300x-26)**

- a. Has there been a change in the *minimum sale age* for tobacco products?**

☐ Yes ☒ No

If Yes, current minimum age: ☐ 19 ☐ 20 ☐ 21

- b. Have there been any changes in State law that impact the State's *protocol for conducting Synar inspections*? ☐ Yes ☒ No**

If Yes, indicate change (check all that apply):

☐ Changed to require that law enforcement conduct inspections of tobacco outlets

☐ Changed to make it illegal for youth to possess, purchase or receive tobacco

☐ Changed to require ID to purchase tobacco

☐ Other change(s) (please describe): _____

- c. Have there been any changes in the law concerning *vending machines*?**

☐ Yes ☒ No

If Yes, indicate change (check all that apply):

☐ Total ban enacted

☐ Banned from location(s) accessible to youth

☐ Locking device or supervision required

☐ Other change(s) (please describe): _____

- d. Have there been any changes in State law that impact the following?**

Licensing of tobacco vendors ☐ Yes ☒ No

Penalties for sales to minors ☐ Yes ☒ No

- 2. Describe how the Annual Synar Report (see 45 C.F.R. 96.130(e)) and the State Plan (see 42 U.S.C. 300x-51) were made public within the State. (Check all that apply)**

☒ Placed on file for public review

☒ Posted on a State agency Web site (Specify Web site location: _____)

☒ Notice published in a newspaper or newsletter

☐ Public hearing

☐ Announced in a news release, a press conference, or discussed in a media interview

- ☒ Distributed for review as part of the SAPT Block Grant application process
- ☐ Distributed through the public library system
- ☐ Published in an annual register
- ☐ Other change(s) (*please describe*): _____

3. Identify the following agency or agencies. (See 42 U.S.C. 300x-26 and 45 C.F.R. 96.130)

a. The State agency(s) *designated by the Governor for oversight of the Synar requirements*:

Arizona Department of Health Services, Division of Behavioral Health Services

Has this changed since last year's Annual Synar Report? ☐ Yes ☒ No

b. The State agency(s) *responsible for conducting random, unannounced Synar inspections*:

Arizona Department of Health Services, Division of Behavioral Health Services

Has this changed since last year's Annual Synar Report? ☐ Yes ☒ No

c. The State agency(s) *responsible for enforcing youth tobacco access law(s)*:

Office of the Attorney General, & local law enforcement agencies

Has this changed since last year's Annual Synar Report? ☐ Yes ☒ No

4. Identify the State agency(s) responsible for tobacco prevention control activities.

Arizona Department of Health Services, Tobacco Education Prevention Program

Has the responsible agency changed since last year's Annual Synar Report?

☐ Yes ☒ No

a. Describe the coordination and collaboration that occur between the agency responsible for tobacco control and the agency responsible for oversight of the Synar requirements. The two agencies (*check all that apply*):

- ☐ Are the same
- ☐ Have a formal written memorandum of agreement
- ☒ Have an informal partnership
- ☒ Conduct joint planning activities
- ☐ Combine resources
- ☐ Have other collaborative arrangement(s) (*please describe*): _____

5. Please answer the following questions regarding the State's activities to enforce the youth access to tobacco law(s) in FFY 2005. (See 42 U.S.C. 300x-26 and 45 C.F.R. 96.130(e))

a. Which one of the following describes the enforcement of youth access to tobacco laws carried out in your State? (Check one category only)

- ☒ Enforcement is conducted exclusively by local law enforcement agencies.
☐ Enforcement is conducted exclusively by State agency(s).
☐ Enforcement is conducted by both local and State agencies.

b. The following items concern penalties imposed for violations of youth access to tobacco laws by LOCAL AND/OR STATE LAW ENFORCEMENT AGENCIES. Please fill in the number requested or indicate if these data are unavailable or the item is not applicable.

PENALTY	NOT APPLICABLE	NOT AVAILABLE	TOTAL	If Available	
				OWNERS	CLERKS
Number of <u>citations issued</u>			55		
Number of <u>finest assessed</u>		<input checked="" type="checkbox"/>			
Number of <u>permits/licenses suspended</u>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			
Number of <u>permits/licenses revoked</u>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			
Other (please describe):					

c. What additional activities are conducted in your State to support enforcement and compliance with State tobacco access law(s)? (Check all that apply)

- ☒ Merchant education and/or training
☒ Incentives for merchants who are in compliance (e.g., Reward and Reminder)
☒ Community education regarding youth access laws
☒ Media use to publicize compliance inspection results
☒ Community mobilization to increase support for retailer compliance with youth access laws
☐ Other activities (please list): _____

Briefly describe all checked activities:

The Arizona Department of Health Services' Tobacco Education Prevention Program requires all Arizona tobacco prevention projects to provide merchant education to the retailers in their county. Two types of education have taken place in the past year – Operation Storefront (youth-based) and CounterActs (retailer training). Operation Storefront's goal is to assist retailers in changing their store policies regarding tobacco advertising and promotions targeted to youth. Youth conduct a survey to calculate the

number of tobacco advertising and promotion in the stores in their communities. They then talk with the retailer about removing or reducing the number of ads and promotions. Some counties have reported the results of their survey to the local newspaper to raise awareness of the problem.

CounterActs is a campaign developed by the Tobacco Education Prevention Program's media contractor. It was developed to educate and encourage support of the retail community in keeping tobacco products away from minors. This campaign offers retailers the opportunity to be a part of the solution in eliminating the sale of tobacco products to children through education and reinforcement. The intent is to reward the clerk when he/she does the right thing by always checking ID's and abiding by the state law. When a clerk is tested and does not sell tobacco products during enforcement activities conducted by local law enforcement that could result in a citation, they are rewarded. This campaign launched as a pilot program in Maricopa County in February 2003, and was expanded to the other counties in January 2004. Incentives rewarded to compliant retailers have included movie tickets, sporting event tickets, food and drink and phone cards.

Local Tobacco Education Prevention Project coordinators offer retailer training to stores to educate their employees on tobacco laws. Maricopa County developed a 30-minute presentation that the other counties are now using. Several counties have quarterly trainings for vendors and offer technical assistance to the retailers to assist their employees in making the right decision about selling to a minor.

SYNAR SURVEY METHODS AND RESULTS

The following questions pertain to the survey methodology and results of the Synar survey used by the State to meet the requirements of the Synar Regulation in FFY 2005. (See 42 U.S.C. 300x-26 and 45 C.F.R. 96.130)

6. Has the sampling methodology changed from the previous year?

☐ Yes ☒ No

The State is required to have an approved up-to-date description of the Synar sampling methodology on file with CSAP. Please submit a copy of your Synar Survey Sampling Methodology (Appendix B). If the sampling methodology changed from the previous reporting year, these changes must be reflected in the methodology submitted.

7. Please answer the following questions regarding the State's annual random, unannounced inspections of tobacco outlets. (See 45 C.F.R. 96.130(d)(2))

a. Did the State use the optional Synar Survey Estimation System (SSES) to analyze the Synar survey data?

☒ Yes ☐ No

If Yes, attach SSES summary tables 1, 2, 3 and 4 and go to Question 8.

If No, continue to Question 7b.

b. Report the weighted and unweighted Retailer Violation Rate (RVR) estimates, and the standard error.

Unweighted RVR

Weighted RVR

Standard error (s.e.) of the (weighted) RVR

Fill in the blanks to calculate the right limit of the right-sided 95% confidence interval.

_____	+	(1.645	×	_____)	=	_____
RVR Estimate	Plus	(1.645	times	Standard Error)	equals	Right Limit

c. Fill out Form 1 in Appendix A (Forms). (Required regardless of the sample design)

d. How were the (weighted) RVR estimate and its standard error obtained?*(Check the one that applies)*

- ☐ Form 2 (Optional) in Appendix A (Forms) *(Attach completed Form 2)*
- ☐ Other *(Please specify. Provide formulae and calculations or attach and explain the program code and output with description of all variable names.)*

e. If stratification was used, did any strata in the sample contain only one outlet or cluster this year?

- ☐ Yes ☐ No ☐ No stratification

*If Yes, explain how this situation was dealt with in variance estimation.***f. Was a cluster sample design used?**

- ☐ Yes ☐ No

*If No, go to Question 7g.**If Yes, fill out and attach Form 3 in Appendix A (Forms), and answer the following question:***Were any certainty primary sampling units selected this year?**

- ☐ Yes ☐ No

*If Yes, explain how the certainty clusters were dealt with in variance estimation.***g. Report the following outlet sample sizes for the Synar survey.**

	Sample Size
Effective sample size (sample size needed to meet the SAMHSA precision requirement assuming simple random sampling)	
Target sample size (the product of the effective sample size and the design effect)	
Original sample size (inflated sample size of the target sample to counter the sample attrition due to ineligibility and non-completion)	
Eligible sample size (number of outlets found to be eligible in the sample)	
Final sample size (number of eligible outlets in the sample for which an inspection was completed)	

h. Fill out Form 4 in Appendix A (Forms).

8. Did the State's Synar survey use a list frame?

☒ Yes ☐ No

If Yes, answer the following questions about its coverage:

a. The calendar year of the latest frame coverage study: 2005

b. Percent coverage from the latest frame coverage study: 90.3%

c. Was a new study conducted in this reporting period? ☒ Yes ☐ No

If Yes, please complete Appendix D (List Sampling Frame Coverage Study) and submit it with the Annual Synar Report.

d. The calendar year of the next coverage study planned: Annually

9. Has the Synar survey inspection protocol changed from the previous year?

☐ Yes ☒ No

The State is required to have an approved up-to-date description of the Synar inspection protocol on file with CSAP. Please submit a copy of your Synar Survey Inspection Protocol (Appendix C). If the inspection protocol changed from the previous year, these changes must be reflected in the protocol submitted.

a. Provide the inspection period: From: 6/1/2005 **To:** 7/28/2005
MM/DD/YY MM/DD/YY

b. Provide the number of youth inspectors used in the current inspection year:
14

c. Fill out and attach Form 5 in Appendix A (Forms). *(Not required if the State used the Synar Survey Estimation System (SSES) to analyze the Synar survey data)*

SECTION II: FFY 2006 (Intended Use):

Public law 42 U.S.C. 300x-26 of the Public Health Service Act and 45 C.F.R. 96.130 (e) (4, 5) require that the States provide information on future plans to ensure compliance with the Synar requirements to reduce youth tobacco access.

1. In the upcoming year, does the State anticipate any changes in the:

Synar sampling methodology ☐ Yes ☒ No

Synar inspection protocol ☐ Yes ☒ No

If changes are made in either the Synar sampling methodology or the Synar inspection protocol, the State is required to obtain approval from CSAP prior to implementation of the change and file an updated Synar Survey Sampling Methodology (Appendix B) or an updated Synar Survey Inspection Protocol (Appendix C), as appropriate.

2. Please describe the State's plans to maintain and/or reduce the retailer violation rate for Synar inspections to be completed in FFY 2006. Include a brief description of plans for law enforcement efforts to enforce youth tobacco access laws, activities that support law enforcement efforts to enforce youth tobacco access laws, and any anticipated changes in youth tobacco access legislation or regulation in the State.

Arizona plans to maintain the target rate for FFY 2006 through continued implementation of its CSAP approved protocols and sampling design. Arizona's plan involves consistent adherence to previous years methods in sampling methodology, inspection protocol, law enforcement activities, merchant education, community education, media use, and community mobilization. No sampling methodology changes are planned.

A portion of the revenue generated from an initiative that significantly raised the tax on tobacco products will be used for tobacco prevention efforts including merchant education. Merchant education, community education, media activities, and community mobilization initiatives continue to be actively developed and implemented by TEPP and will be shared with CSAP as they occur. The Department of Revenue Retail List will continue to be updated and will likely continue to be problematic. The list suffers from too many establishments identified that do not sell tobacco products and fails to include many businesses that do sell tobacco. Information from the Attorney General's retail inspection list will be incorporated into the ADHS list to improve accuracy.

3. Describe any challenges the State faces in complying with the Synar regulation. (Check all that apply)

- ☐ Limited resources for law enforcement of youth access laws
- ☐ Limited resources for activities to support enforcement and compliance with youth tobacco access laws
- ☐ Limitations in the State youth tobacco access laws
- ☐ Limited public support for enforcement of youth tobacco access laws
- ☒ Limitations on completeness/accuracy of list of tobacco outlets
- ☐ Limited expertise in survey methodology
- ☐ Laws/regulations limiting the use of minors in tobacco inspections
- ☐ Difficulties recruiting youth inspectors
- ☐ Geographic, demographic, and logistical considerations in conducting inspections
- ☐ Cultural factors (e.g., language barriers, young people purchasing for their elders)
- ☐ Issues regarding sources of tobacco under tribal jurisdiction
- ☐ Other challenges (please list): _____
- ☐ No challenges (please explain): _____

Briefly describe all items checked above:

The tobacco outlet list is updated annually through two methods: results of the previous inspections and information from the Arizona Department of Revenue.

In the first method, the list is updated using information gained during inspections in the previous year. New businesses found to sell tobacco are added to the list and businesses that no longer exist or do not sell tobacco products are removed from the list. Since compliance inspections are conducted with approximately one third of all vendors State wide, only one third of the entire list is updated using this first method.

The second method is the routine tax stamp inspections by the Arizona Department of Revenue. Although the Department of Revenue conducts inspections on an annual basis, the number verified may change from year to year and in most years does not include a large number of vendors. Therefore, this source provides a limited amount of information.

Enforcement initiated by the Arizona Office of the Attorney General is another source of data to improve the list of tobacco outlets.

APPENDIX A: FORMS

FORM 1 (Required for all States not using the Synar Survey Estimation System (SSES) to analyze the Synar Survey data)

Complete Form 1 to report sampling frame and sample information and to calculate the unweighted retailer violation rate using results from the current year's Synar survey inspections.

Instructions for Completing Form 1: In the top right hand corner of the form, provide the State name and reporting Federal fiscal year (FFY 2006). Provide the remaining information by stratum if stratification was used. Make copies of the form if additional rows are needed to list all the strata.

Column 1: *If stratification was used:*

1(a) Sequentially number each row.

1(b) Write in the name of each stratum. All strata in the State must be listed.

If no stratification was used:

1(a) Leave blank.

1(b) Write "State" in the first row (indicates that the whole state is a single stratum).

Note for unstratified samples: for columns 2-5, wherever the instruction refers to "each stratum," report the specified information for the State as a whole.

Column 2: 2(a) Report the number of over-the-counter (OTC) outlets in the sampling frame in each stratum.

2(b) Report the number of vending machine (VM) outlets in the sampling frame in each stratum.

2(c) Report the combined total of OTC and VM outlets in the sampling frame in each stratum.

Column 3: 3(a) Report the estimated number of eligible OTC outlets in the OTC outlet population in each stratum.

3(b) Report the estimated number of eligible VM outlets in the VM outlet population in each stratum.

3(c) Report the combined total estimated number of eligible OTC and VM outlets in the total outlet population in each stratum.

The estimates for Column 3 can be obtained from the Synar survey sample as the weighted sum of eligible outlets by outlet type.

Column 4: 4(a) Report the number of eligible OTC outlets for which an inspection was completed, for each stratum.

4(b) Report the numbers of eligible VM outlets for which an inspection was completed, for each stratum.

4(c) Report the combined total of eligible OTC and VM outlets for which an inspection was completed, for each stratum.

Column 5: 5(a) Report the number of OTC outlets found in violation of the law as a result of completed inspections, for each stratum.

5(b) Report the number of VM outlets found in violation of the law as a result of completed inspections, for each stratum.

5(c) Report the combined total of OTC and VM outlets found in violation of the law as a result of completed inspections, for each stratum.

Totals: For each sub-column (a-c) in Columns 2-5, provide totals for the State as a whole in the last row of the table. These numbers will be the sum of the numbers in each row for the respective column.

FORM 1 (Required for all States not using the Synar Survey Estimation System (SSES) to analyze the Synar Survey data)

Summary of Synar Inspection Results by Stratum													
													State FFY 2006
(1)		(2)			(3)			(4)			(5)		
STRATUM		NUMBER OF OUTLETS IN SAMPLING FRAME			ESTIMATED NUMBER OF ELIGIBLE OUTLETS IN POPULATION			NUMBER OF OUTLETS INSPECTED			NO. OF OUTLETS FOUND IN VIOLATION DURING INSPECTIONS		
(a) Row #	(b) Stratum Name	(a) Over-the-Counter (OTC)	(b) Vending Machines (VM)	(c) Total Outlets (2a+2b)	(a) Over-the-Counter (OTC)	(b) Vending Machines (VM)	(c) Total Outlets (3a+3b)	(a) Over-the-Counter (OTC)	(b) Vending Machines (VM)	(c) Total Outlets (4a+4b)	(a) Over-the-Counter (OTC)	(b) Vending Machines (VM)	(c) Total Outlets (5a+5b)

RECORD COLUMN TOTALS ON LAST LINE (LAST PAGE ONLY IF MULTIPLE PAGES ARE NEEDED)

FORM 2 (Optional)

Appropriate for stratified simple or systematic random sampling designs.

Complete Form 2 to calculate the weighted RVR. This table (in Excel form) is designed to calculate the weighted RVR for stratified simple or systematic random sampling designs, accounting for ineligible outlets and non-complete inspections encountered during the annual Synar survey.

Instructions for Completing Form 2:

In the top right hand corner of the form, provide the State name and reporting Federal fiscal year (FFY 2006).

- Column 1: Write in the name of each stratum into which the sample was divided. These should match the strata reported in Column 1(b) of Form 1.
- Column 2: Report the number of outlets in the sampling frame in each stratum. These numbers should match the numbers reported for the respective strata in Column 2(c) of Form 1.
- Column 3: Report the original sample size (the number of outlets originally selected, including substitutes or replacements) for each stratum.
- Column 4: Report the number of sample outlets in each stratum that were found to be eligible during the inspections. Note that this number must be less than or equal to the number reported in Column 3 for the respective strata.
- Column 5: Report the number of eligible outlets in each stratum for which an inspection was completed. Note that this number must be less than or equal to the number reported in Column 4. These numbers should match the numbers reported in Column 4(c) of Form 1 for the respective strata.
- Column 6: Report the number of eligible outlets inspected in each stratum that were found in violation. These numbers should match the numbers reported in Column 5(c) of Form 1 for the stratum.
- Column 7: Form 2 (in Excel form) will automatically calculate the stratum RVR for each stratum in this column. This is calculated by dividing the number of inspected eligible outlets found in violation (Column 6) by the number of inspected eligible outlets (Column 5). The State unweighted RVR will be shown in the Total row of Column 7.
- Column 8: Form 2 (in Excel form) will automatically calculate the estimated number of eligible outlets in the population for each stratum. This calculation is made by multiplying the number of outlets in the sampling frame (Column 2) times the number of eligible outlets (Column 4) divided by the original sample size (Column 3). Note that these numbers will be less than or equal to the numbers in Column 2.
- Column 9: Form 2 (in Excel form) will automatically calculate the relative stratum weight by dividing the estimated number of eligible outlets in the population for each stratum in Column 8 by the Total of the values in Column 8.
- Column 10: Form 2 (in Excel form) will automatically calculate each stratum's contribution to the State weighted RVR by multiplying the stratum RVR (Column 7) by the relative stratum weight (Column 9). The weighted RVR will be shown in the Total row of Column 10.
- Column 11: Form 2 (in Excel form) automatically calculates the standard error of each stratum's RVR (Column 7). The standard error for the State weighted RVR will be shown in the Total row of Column 11.
- TOTAL: For Columns 2-6, Form 2 (in Excel form) provides totals for the State as a whole in the last row of the table. For Columns 7-11, it calculates the respective statistic for the State as a whole.

FFY: 2006 State: Arizona
Date: 2006

FORM 2 (Optional) Appropriate for stratified simple or systematic random sampling designs.

Calculation of Weighted Retailer Violation Rate										
										State: <u> </u>
										FFY: <u>2006</u>
(1) Stratum Name	(2) N Number of Outlets in Sampling Frame	(3) n Original Sample Size	(4) n1 Number of Sample Outlets Found Eligible	(5) n2 Number of Outlets Inspected	(6) x Number of Outlets Found in Violation	(7) p=x/n2 Stratum Retailer Violation Rate	(8) N'=N(n1/n) Estimated Number of Eligible Outlets in Population	(9) w=N'/Total Column 8 Relative Stratum Weight	(10) pw Stratum Contribution to State Weighted RVR	(11) s.e. Standard Error of Stratum RVR
TOTAL										

- N - number of outlets in sampling frame
- n - original sample size (number of outlets in the original sample)
- n1 - number of sample outlets that were found to be eligible
- n2 - number of eligible outlets that were inspected
- x - number of inspected outlets that were found in violation
- p - stratum retailer violation rate ($p=x/n2$)
- N' - estimated number of eligible outlets in population ($N'=N*n1/n$)
- w - relative stratum weight ($w=N'/\text{Total Column 8}$)
- pw - stratum contribution to the weighted retailer violation rate
- s.e. - standard error of the stratum RVR

FORM 3 (Required when a cluster design is used for all States not using the Synar Survey Estimation System (SSES) to analyze the Synar survey data)

Complete Form 3 to report information about primary sampling units when a cluster design was used for the Synar survey.

Instructions for Completing Form 3:

In the top right hand corner of the form, provide the State name and reporting Federal fiscal year (FFY2006).

Provide information by stratum if stratification was used. Make copies of the form if additional rows are needed to list all the strata.

Column 1: Sequentially number each row.

Column 2: *If stratification was used:* Write in the name of stratum. All strata in the State must be listed.

If no stratification was used: write "State" in the first row to indicate that the whole state constitutes a single stratum.

Column 3: Report the number of primary sampling units (PSUs) (i.e., first-stage clusters) created for each stratum.

Column 4: Report the number of PSUs selected in the original sample for each stratum.

Column 5: Report the number of PSUs in the final sample for each stratum.

TOTALS: For Columns 3-5, provide totals for the State as a whole in the last row of the table.

Summary of Clusters Created and Sampled				
				State:
				FFY: 2006
(1) Row #	(2) Stratum Name	(3) Number of PSUs Created	(4) Number of PSUs Selected	(5) Number of PSUs in the Final Sample
TOTAL				

FORM 4 (Required for all States not using the Synar Survey Estimation System (SSES) to analyze the Synar Survey data)

Complete Form 4 to provide detailed tallies of ineligible sample outlets by reasons for ineligibility and detailed tallies of eligible sample outlets with noncomplete inspections by reasons for noncompletion.

Instructions for Completing Form 4:

In the top right hand corner of the form, provide the State name and reporting Federal fiscal year (FFY2006).

Column 1(a): Enter the number of sample outlets found ineligible for inspection by reason for ineligibility. Provide the total number of ineligible outlets in the row marked **“Total”**.

Column 2(a): Enter the number of eligible sample outlets with noncomplete inspections by reason for noncompletion. Provide the total number of eligible outlets with noncomplete inspections in the row marked **“Total”**.

Inspection tallies by reason of ineligibility or noncompletion <div style="text-align: right;"> State FFY 2006 </div>			
(1) INELIGIBLE		(2) ELIGIBLE	
Reason for ineligibility	(a) Counts	Reason for noncompletion	(a) Counts
Out of business		In operation but closed at time of visit	
Does not sell tobacco products		Unsafe to access	
Inaccessible by youth		Presence of police	
Private club or private residence		Youth inspector knows salesperson	
Temporary closure		Moved to new location	
Unlocatable		Drive thru only/youth inspector has no driver's license	
Wholesale only/Carton sale only		Tobacco out of stock	
Vending machine broken		Run out of time	
Duplicate		Other noncompletion reason(s) <i>(describe)</i>	
Other ineligibility reason(s) <i>(describe)</i>			
Total		Total	

FORM 5 (Required for all States not using the Synar Survey Estimation System (SSES) to analyze the Synar survey data)

Complete Form 5 to show the distribution of outlet inspection results by age and gender of the youth inspectors.

Instructions for Completing Form 5:

In the top right hand corner of the form, provide the State name and reporting Federal fiscal year (FFY2006).

Column 1: Enter the number of attempted buys by youth inspector age and gender.

Column 2: Enter the number of successful buys by youth inspector age and gender.

If the inspectors are age eligible but the gender of the inspector is unknown, include those inspections in the "OTHER" row. Calculate subtotals for males and females in rows marked SUBTOTALS. Sum SUBTOTALS for male, female, and OTHER and record in the bottom row marked TOTAL. Verify that that the TOTAL of attempted buys and successful buys equal the total for Column 4(c) and Column 5(c), respectively, on Form 1. If the totals do not match, please explain any discrepancies.

Synar Survey Inspector Characteristics		State
		FFY 2006
	(1) Attempted Buys	(2) Successful Buys
<u>Male</u>		
14 yrs		
15 yrs		
16 yrs		
17 yrs		
18 yrs		
MALE SUBTOTAL		
<u>Female</u>		
14 yrs		
15 yrs		
16 yrs		
17 yrs		
18 yrs		
FEMALE SUBTOTAL		
OTHER		
TOTAL		

APPENDIX B

STATE: Arizona
FFY: 2006

SYNAR SURVEY SAMPLING METHODOLOGY

1. What type of sampling frame is used?

- ☐ List frame (Go to Question 2)
☐ Area frame (Go to Question 3)
☒ List-assisted area frame (Go to Question 2)

2. List all sources of the list frame. Indicate the type of source from the list below. Provide a brief description of the frame source. Explain how the lists are updated (method), including how new outlets are identified and added to the frame. In addition, explain how often the lists are updated (cycle). (After completing this question, go to Question 4)

Use the corresponding number to indicate Type of Source in the table below:

- 1 – Statewide commercial business list 4 – Statewide retail license/permit list
 2 – Local commercial business list 5 – Statewide liquor license/permit list
 3 – Statewide tobacco license/permit list 6 – Other

Name of Frame Source	Type of Source	Description	Updating Method and Cycle
Previous Year's Frame	Originally a 1	This is the list used for last years sample	Annually (ADHS)
New outlets from last years sample	6	We sample 33% of all clusters each year and find any businesses not in the frame	Annually (ADHS)
New outlets from the Arizona Department of Revenue	6	Inspection list used to inspect outlets for use of the tobacco stamp	Annually (ADOR)

3. If an area frame is used, describe how area sampling units are defined and formed

Contiguous zip codes are used to create an area frame of cluster areas in Arizona, each with approximately 40-45 outlets based on the list frame.

- a. Is any area left out in the formation of the area frame?** ☒ Yes ☐ No

If Yes, what percentage of the State's population is not covered by the area frame?

Native American Reservations are not included Approx. 2.5%

4. Federal regulation requires that vending machines be inspected as part of the Synar survey. Are vending machines included in the Synar survey?

☐ Yes ☒ No

If No, please indicate the reason they are not included in the Synar survey.

☐ State law bans vending machines

☒ State law bans vending machines from locations accessible to youth

☒ State has SAMHSA approval to exempt vending machines from the survey

☐ Other (please describe): _____

5. Which category below best describes the sample design? (Check only one)

☐ **Census** (STOP HERE: Appendix B is complete)

Unstratified State-wide sample:

☐ Simple random sample (go to Question 9)

☐ Systematic random sample (go to Question 6)

☒ Single-stage cluster sample (go to Question 8)

☐ Multi-stage cluster sample (go to Question 8)

Stratified sample:

☐ Simple random sample (go to Question 7)

☐ Systematic random sample (go to Question 6)

☐ Single-stage cluster sample (go to Question 7)

☐ Multi-stage cluster sample (go to Question 7)

☐ **Other** (please describe and go to Question 9): _____

6. Describe the systematic sampling methods. (After completing Question 6, go to Question 7 if stratification is used. Otherwise go to Question 9.)

7. Provide the following information about stratification

a. Provide a full description of the strata that are created.

b. Is clustering used within the stratified sample?

☐ **Yes** (go to Question 8)

☐ **No** (go to Question 9)

8. Provide the following information about clustering

a. Provide a full description of how clusters are formed. *(If multi-stage clusters are used, give definitions of clusters at each stage.)*

Contiguous zip codes are used to create an area frame of cluster areas in Arizona, each with approximately 40-45 outlets based on the list frame. The cluster is defined by its zip codes. A map of Arizona's zip codes combined with the number of outlets in each zip code are used to make decisions on which zip codes are combined to form a cluster.

Clusters are defined by their composite zip code boundaries. Clusters are updated annually to ensure an average of 40-45 outlets per cluster. Updating the cluster involves the steps listed below, which are completed under the supervision on the ADHS statistician in charge of the sample as a step in developing the final cluster design:

1. Assign new vendors to the appropriate cluster.
2. Remove vendors that were identified as ineligible (e.g., no longer in business) during the previous year's survey.
3. Reassign to the correct cluster all tobacco outlets that were found to be in the wrong cluster in the previous year's survey.
4. Divide clusters that have grown larger than 80 tobacco outlets per cluster.
5. Combine adjacent zip code clusters with fewer than 20 tobacco outlets.
6. Conduct final review and delineation of cluster boundaries to ensure that they are well defined and appropriately contiguous for survey purposes.

b. Specify the sampling method (simple random, systematic, or probability proportional to size sampling) for each stage of sampling and describe how the method(s) is (are) implemented.

The method used was simple random sample of clusters (single stage cluster sample). All outlets are inspected within each cluster including all new outlets found in the cluster area.

Generate N (unique) random numbers and assign one to each cluster. Order the clusters in ascending order of the random numbers. The resulting list is a randomly sorted, and from the sorted list clusters are accepted into the sample until the first designated number of clusters are drawn. This number is larger than the cluster sample size determined by the sample size determination procedure.

The first required number of clusters in the sample, as determined by sample size determination procedure, are released to the fieldwork contractors. The remaining clusters are released one at a time, as needed, in the same order as they are selected.

Each cluster entered for inspection must be comprehensively canvassed for all tobacco outlets, which must then be inspected along with the pre-listed outlets.

9. Provide the formulae for determining the effective, target, and original outlet sample sizes.

Effective sample size (ESS) = $p(1-p) / \text{Var}(p)$, where $p = 0.2$ or previous year's RVR and $\text{Var}(p) = (0.03/1.645)^2 = 0.0003326$, which is the maximum variance to meet the SAMHSA precision requirement of 3 percent of margin of error for right-sided 95% confidence interval for RVR.

Target Sample Size (TSS) = (ESS)*(DE), where DE is the design effect coming from the previous year's survey.

Original Outlet Sample Size = (TSS)/Accuracy Rate, where the accuracy rate obtained from the previous year's survey.

The cluster sample size is then determined by (Original Outlet Sample Size)/(Average Cluster Size).

APPENDIX C

STATE: Arizona
FFY: 2006

SYNAR SURVEY INSPECTION PROTOCOL

Note: Attach a copy of the inspection form and protocol used to record the inspection result.

1. How does the State Synar survey protocol address the following?

a. Consummated buy attempts?

- ☒ Required ☐ Not Permitted
☐ Permitted under specified circumstances ☐ Not specified in protocol

b. Youth inspectors to carry ID?

- ☐ Required ☒ Not Permitted
☐ Permitted under specified circumstances ☐ Not specified in protocol

c. Adult inspectors to enter the outlet?

- ☐ Required ☐ Not Permitted
☒ Permitted under specified circumstances ☐ Not specified in protocol

d. Youth inspectors to be compensated?

- ☒ Required ☐ Not Permitted
☐ Permitted under specified circumstances ☐ Not specified in protocol

2. Identify the agency(s) or entity(s) that actually conduct the random, unannounced Synar inspections of tobacco outlets. (Check all that apply)

- ☐ Law enforcement agency(s)
☐ State or local government agency(s) other than law enforcement
☒ Private contractor(s)
☐ Other

List the agency name(s): Pima Prevention Partnership; Community Bridges

3. Are Synar inspections combined with law enforcement efforts (i.e., do law enforcement issue warnings or citations to retailers found in violation of the law at the time of the inspection)?

- ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☒ Never

4. Describe the methods used to recruit, select, and train youth inspectors and adult supervisors.

One to three Arizona prevention providers with experience in tobacco inspections and working with youth are used to conduct compliance inspections in 2005.

Each provider is responsible for recruiting between 4 and 10 16-year-old youth from their prevention programs to conduct inspections. The ethnic composition of the youth typically reflects the ethnic composition of Arizona youth. Age testing is completed for the youth who participate in the study. Supporting documents are collected from all youth inspectors and include birth certificates, age appearance tests, permission slips, current photos, and photo identifications. In every case a parent provides active consent for youth to participate in the project. Youth also sign an active consent form stating that they are willing to participate in the project. Youth are paid for participation in the inspections. There is no reward or penalty for making purchases. No youth is permitted to miss school to conduct inspections.

Adults are recruited from the identified prevention providers as chaperones. Chaperones are responsible for driving the vehicle, navigation, maintenance of youth inspector safety, taking care of youth inspector needs for food and breaks, and for accurate completion of paperwork. Chaperones are encouraged to have a second adult ride with them during inspections to navigate and/or complete documentation.

All providers including adult chaperones and youth inspectors are required to participate in an interactive group training held before inspections commence. Using a standardized curriculum, training objectives are designed to help inspection teams understand the Federal SYNAR requirements and inspection protocols.

Training commences with introductions, a review of the agenda and articulation of expectations for the training. Responsibilities of youth inspectors, adult inspectors, and the Department are reviewed in the training. Purchase protocols are trained in depth. Training is reinforced with a series of role-plays in which youth inspectors' practice entering stores and attempting to make tobacco inspection purchases.

Additional training topics include safety and supervision of youth inspectors, maintaining professional boundaries with youth inspectors, and making inspections fun. Department staff provide guidelines to contractors including schedule inspections for no more than eight hours in a day, providing lunch for inspection teams, and appropriate use of work breaks as needed. Finally, the training covers logistical issues such as the number of inspections, locations, and projected dates of inspections. Adult escorts participate in an administrative meeting in which payment for services delivered is discussed as well as procedures for documenting, collecting and turning in inspection forms.

ADHS staff conduct field monitoring of the inspection teams for approximately 30 - 50% of the field time. ADHS staff provide feedback, answer questions, and verify adherence to field protocols during monitoring. Additionally, providers communicate directly with DBHS during the inspections regarding questions that arise.

5. Are there specific legal or procedural requirements instituted by the State to address the issue of youth inspectors' immunity when conducting inspections?

a. Legal ☐ **Yes** ☒ **No** *(If Yes, please describe):*

b. Procedural ☒ **Yes** ☐ **No** *(If Yes, please describe):*

The Arizona Department of Health Services sends a letter to county attorneys across the state informing them that SYNAR inspections will be taking place and inviting them to contact ADHS should they have questions or concerns.

6. Are there specific legal or procedural requirements instituted by the State to address the issue of the safety of youth inspectors during all aspects of the Synar inspection process?

a. Legal ☐ **Yes** ☒ **No** *(If Yes, please describe):*

b. Procedural ☒ **Yes** ☐ **No** *(If Yes, please describe):*

Inspection teams including youth inspectors and adult supervisors receive training in safety procedures prior to commencement of inspections. Teams are instructed to not inspect any business that they perceive to be unsafe. Businesses not inspected for these reasons are documented. The protocol also allows adult supervisors to inconspicuously enter a business before and separate from the youth inspector to assess safety.

7. Are there any other legal or procedural requirements the State has regarding how inspections are to be conducted (e.g., age of youth inspector, time of inspections, training that must occur)?

a. Legal ☐ **Yes** ☒ **No** *(If Yes, please describe):*

b. Procedural ☒ **Yes** ☐ **No** *(If Yes, please describe):*

All youth inspectors must be age 16. The gender balance of selected youth is 50% female and 50% male. Exceptions to the gender balance take place when unexpected events arise, such as a resignation of a youth inspector. Inspections occur at a variety of times during the day and days of the week including weekends. All youth inspectors are required to complete training provided by ADHS. ADHS staff perform field monitoring on approximately half of all inspections.

APPENDIX D

STATE: Arizona

FFY: 2006

List Sampling Frame Coverage Study (LIST FRAME ONLY)

- 1. Calendar year of the coverage study:** 2005

- 2. Percent coverage found:** 90.3 %

(Provide calculation of the percent coverage)

Coverage **Eligible outlets in Sample/ (Eligible outlets + new outlets found)**
=(1525)/(1525 + 164) = .903

3. Provide a description of the coverage study methods and results.

Arizona begins with a list-assisted sample, which is enhanced each year during the compliance study by the comprehensive review of all outlets within the zip code cluster*. Those outlets determined eligible for the study (e.g. sell tobacco) are added to the list and surveyed by the SYNAR field team. This allows Arizona to calculate the coverage of the original list on an annual basis. For CY2005, the SYNAR teams found 164 new outlets not on the original vendor list.

*Instructions are to visit all on the list for that cluster, and discover all other outlets selling tobacco products, effectively resulting in a comprehensive canvassing of every cluster inspected.

Arizona Youth Tobacco Purchase Survey, 2005

Vendor Information:

Name _____

Street Address _____

City _____ Zip Code _____ Cluster Number _____

**Please note any business name changes and correct the address. If this business is a duplicate of another business listed, please indicate so by writing the word duplicate below.*

Is this a *new* vendor (i.e. one that was not on the original list)?

☐ Yes ☐ No

Does this vendor sell tobacco?

☐ Yes ☐ No

Was the vendor inspected? (i.e. Did the youth enter the facility and attempt to purchase tobacco?)

☐ Yes ☐ No

If the vendor ***was not*** inspected, check the reason why and ***do not*** fill out the rest of this form:

- | | |
|--|--|
| <input type="checkbox"/> Inaccessible by youth | <input type="checkbox"/> Out of business |
| <input type="checkbox"/> Private club | <input type="checkbox"/> No longer exists/unable to locate |
| <input type="checkbox"/> There was only a vending machine | |
| <input type="checkbox"/> Unsafe environment (please describe what made this environment unsafe): | |
| <input type="checkbox"/> Other reason (please describe): _____ | |

- ☐ Police officers present
☐ Youth inspector knew store employee(s)
☐ In operation, but closed at time of visit

If you check here, you must try to survey the store again

Complete this part ***only if the vendor was inspected***

Did the vendor sell the tobacco to the youth inspector?

☐ Yes ☐ No

Type of tobacco purchased:

☐ Cigarettes ☐ Chewing tobacco ☐ Cigar

Type of Vendor:

- | | | |
|--|--|--|
| <input type="checkbox"/> Gas station only | <input type="checkbox"/> Stand alone bar | <input type="checkbox"/> Hotel/motel |
| <input type="checkbox"/> Drug store/pharmacy | <input type="checkbox"/> Market | <input type="checkbox"/> Discount store |
| <input type="checkbox"/> Restaurant | <input type="checkbox"/> Liquor store | <input type="checkbox"/> Duty Free Shop |
| <input type="checkbox"/> Bowling alley | <input type="checkbox"/> Tobacco store | <input type="checkbox"/> Other, specify: |
| <input type="checkbox"/> Supermarket | <input type="checkbox"/> Convenience store (with or without gas) | |

Did the youth ask the clerk for the tobacco?

☐ Yes ☐ No, the tobacco was self serve

Clerk characteristics:

Gender: ☐ Male ☐ Female

Approximate Age: ☐ 25 or younger ☐ Over 25

Protocol Used to Record the Inspection Results

An inspection form is completed immediately after each inspection. The adult escort debriefed the youth after returning to the car. Purchased tobacco products were turned over to the adult who destroyed them. All inspection forms were completed for locations tested. Inspection forms captured the following data elements:

Date and time	Type of tobacco requested
Retailer from assist list or newly found	Type of outlet
Cluster number	Whether tobacco was self serve or requested from clerk
Business name	Clerk demographics including gender & approximate age
Street address	Chaperone name
City	Chaperone signature
Zip code	Youth inspector initials
Youth inspector identification number	Sale outcome

The inspection teams review inspection documentation forms for accuracy and completeness. Forms are then signed by the adult supervisor and initialed by the youth inspector. When ADHS representatives are with the team, they also review inspection documentation forms for completeness. Upon submission to the Arizona Department of Health Services, forms are reviewed for completeness and entered into a SYNAR database. This year, no corrections were requested from inspection teams.

SSES Table 1 (Synar Survey Estimates and Sample Sizes)**CSAP-SYNAR REPORT**

State	AZ
Federal Fiscal Year (FFY)	2006
Date	8/22/2005 11:14
Data	SSESDataEntryTemplate-Cluster 2005.xls
Analysis Option	Stratified Clustered with FPC

Estimates

Unweighted Retailer Violation Rate	7.6%
Weighted Retailer Violation Rate	7.7%
Standard Error	0.8%
Is SAMHSA Precision Requirement met?	YES
Right-sided 95% Confidence Interval	[0.0%, 9.0%]
Two-sided 95% Confidence Interval	[6.2%, 9.3%]
Design Effect	2.8
Accuracy Rate (unweighted)	67.1%
Accuracy Rate (weighted)	67.1%
Completion Rate (unweighted)	98.4%

Sample Size for Current Year

Effective Sample Size	481
Target (Minimum) Sample Size	1,684
Original Sample Size	2,559
Eligible Sample Size	1,716
Final Sample Size	1,689
Overall Sampling Rate	46.0%

SSES Table 2 (Synar Survey Results by Stratum and by OTC/VM)

STATE: AZ

FFY: 2006

Samp. Stratum	Var. Stratum	Outlet Frame Size	Estimated Outlet Population Size	Number of PSU Clusters Created	Number of PSU Clusters in Sample	Outlet Sample Size	Number of Eligible Outlets in Sample	Number of Sample Outlets Inspected	Number of Sample Outlets in Violation	Retailer Violation Rate(%)	Standard Error(%)
All Outlets											
1	1	5,510	5,491	128	53	2,559	1,716	1,689	129	7.7%	
Total		5,510	5,491	128	53	2,559	1,716	1,689	129	7.7%	0.8%
Over the Counter Outlets											
1	1	5,510	5,491	128	53	2,559	1,716	1,689	129	7.7%	
Total		5,510	5,491	128	53	2,559	1,716	1,689	129	7.7%	0.8%
Vending Machines											
1	1	0	0	128	53	0	0	0	0	0.0%	
Total		0	0	128	53	0	0	0	0	0.0%	0.0%

SSES Table 3 (Synar Survey Sample Tally Summary)

 STATE: AZ
 FFY: 2006

Disposition Code	Description	Count	Subtotal
EC	Eligible and inspection complete outlet	1689	
Total (Eligible Completes)			1689
N1	In operation but closed at time of visit	19	
N2	Unsafe to access	5	
N3	Presence of police	2	
N4	Youth inspector knows salesperson	0	
N5	Moved to new location but not inspected	0	
N6	Drive thru only/youth inspector has no drivers license	0	
N7	Tobacco out of stock	0	
N8	Run out of time	0	
N9	Other noncompletion (see below)	1	
Total (Eligible Noncompletes)			27
I1	Out of Business	153	
I2	Does not sell tobacco products	183	
I3	Inaccessible by youth	97	
I4	Private club or private residence	5	
I5	Temporary closure	0	
I6	Unlocatable	268	
I7	Wholesale only/Carton sale only	0	
I8	Vending machine broken	0	
I9	Duplicate	126	
I10	Other ineligibility (see below)	11	
Total (Ineligibles)			843
Grand Total			2559

Give reasons and counts for other noncompletion:

Reason	Count
Overlooked by provider	1

Give reasons and counts for other ineligibility:

Reason	Count
On Tribal lands	4
Not in assigned cluster	7

SSES Table 4 (Synar Survey Inspection Results by Youth Inspector Characteristics)

STATE: AZ

FFY: 2006

Frequency Distribution

Gender	Age	Number of Inspectors	Attempted Buys	Successful Buys
Male	14	0	0	0
	15	0	0	0
	16	6	850	88
	17	1	114	4
	18	0	0	0
	Subtotal	7	964	92
Female	14	0	0	0
	15	0	0	0
	16	7	725	37
	17	0	0	0
	18	0	0	0
	Subtotal	7	725	37
Other		0	0	0
Grand Total		14	1689	129

Buy Rate in Percent by Age and Gender

Age	Male	Female	Total
14	0.0%	0.0%	0.0%
15	0.0%	0.0%	0.0%
16	10.4%	5.1%	7.9%
17	3.5%	0.0%	3.5%
18	0.0%	0.0%	0.0%
Other			0.0%
Total	9.5%	5.1%	7.6%